

AN INVESTMENT IN THE FUTURE / FINAL REPORT

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**COMPREHENSIVE
STATEWIDE PLANNING
FOR
VOCATIONAL
REHABILITATION
SERVICES**

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Nebraska: Services for the Visual
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Final report; comprehensive
statewide planning for vocational
rehabilitation services.

Tom Phillips

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FINAL REPORT

COMPREHENSIVE STATEWIDE PLANNING FOR
VOCATIONAL REHABILITATION SERVICES

NEBRASKA

Services for the Visually Impaired
State Capitol Building
Lincoln, Nebraska

JACK HOBBS
Project Director

HERBERT J. LARSON
Assn't. Project Director

September 15, 1966 - January 31, 1969

This planning program was supported by a grant, under Section 4(a)(2) (b) from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D. C.

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STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

January 6, 1969

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The Honorable Norbert T. Tiemann
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State Capitol Building
Lincoln, Nebraska 68509

Dear Sir:

It is an honor to submit the final report of the Statewide Planning for Vocational Rehabilitation Services. This project was authorized September 15, 1966, by a grant from the Federal Office of Health, Education, and Welfare to the Department for the Visually Impaired.

This study was compiled by the Project Director, Jack Hobbs, with the guidance and advice of a Policy Board appointed by former Governor Frank B. Morrison.

Many hours of volunteer work by private citizens accomplished the gathering of statistical facts used in this study.

The Policy Board members believe the study provides factual statistics which substantiate the number of persons in need of rehabilitation services, as well as the kinds of services. Present programs have been studied and recommendations provided for the necessary changes, improvement, and expansion of Rehabilitation Services.

It is the hope of the Policy Board that our findings and recommendations will be given your kind consideration.

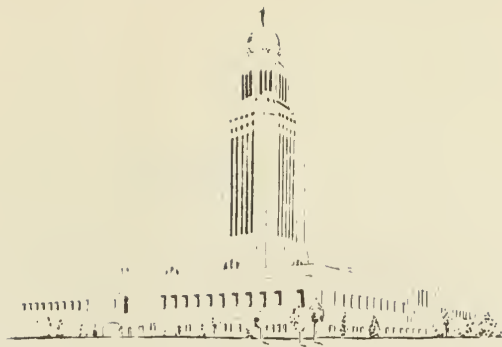
The Board members are willing to expand on any questions you may have, with the hope that this study will bring about beneficial results in fulfilling the needs of a large segment of Nebraska's population.

Sincerely yours,

Calista Cooper Hughes

Calista Cooper Hughes
POLICY BOARD CHAIRMAN

NORBERT T. TIEMANN
GOVERNOR



STATE *of* NEBRASKA
EXECUTIVE OFFICE
LINCOLN
68509

January 7, 1969

My Fellow Citizens:

It is with pleasure that I present you a copy of the final report of Statewide Planning for Rehabilitation Services for the State of Nebraska.

The Services for the Visually Impaired, a Rehabilitation Agency for this state, received a federal grant on September 15, 1966. This grant provided 100% federal funding from the Department of Health, Education and Welfare so that a study could be completed on the needs and problems of rehabilitation programs in this state.

Several hundred Nebraskans have participated in this study on a voluntary basis and I would like to thank them for their productive efforts.


The policy board which gave considerable time to this study, the regional chairmen and the staff of the project office are awarded a special "thank you" for all their good work.

Each recommendation of this study will be given serious consideration by the Governor's staff and by all of the state senators. Efforts for implementation will begin immediately.

The most important issue in this document is the handicapped themselves. Nebraska's state Rehabilitation Agencies exist only to provide services to the handicapped. They try to insure that each handicapped person will have an equal chance of being provided services so he may be prepared and entered into employment. It is my trust that we in Nebraska can steadily improve our services to achieve this goal.

Respectfully,

NORBERT T. TIEMANN
Governor



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FOREWARD

Since 1921, or a period of forty-seven years, the State of Nebraska has provided vocational-rehabilitation services to its handicapped people of employable age. This has been accomplished through its State Rehabilitation Agencies. The legislators of this state have been interested in this program and have repeatedly asked the difficult question: How many handicapped are living in Nebraska that are in need and could benefit from rehabilitation services. The answer to this question would establish a base for determining how well the handicapped are being served and what plans need to be considered for providing an adequate service program to this group of people. Prior to the publishing of this report, these questions have never been answered satisfactorily due to lack of research information in this field for this state.

In 1965, members of the Congress as well as experts of the Vocational Rehabilitation Administration of Washington, D. C. expressed considerable interest in the report of the National Health Survey. The findings of this study were felt to be of vital importance to administrators of agencies responsible for programs of rehabilitation whether the individual program was local, state, regional or national in its, scope.

The National Health Interview Survey of the National Center for Health Statistics, Public Health Service, showed that throughout the United States there existed a backlog of 3.7 million disabled persons who could benefit from rehabilitation services. A projection indicated that same year, it was predicted that annually there would be 500,000 newly handicapped persons that would need rehabilitation services.

The rehabilitation services as provided by the state programs are designed to return handicapped citizens to employment. This work has been financed on a partnership basis between the federal government and the state governments since 1921. Today, the federal office of Vocational Rehabilitation Administration provides large sums of money on a federal state matching basis as well as expert guidance and direction to help the states achieve their goal of rehabilitating the handicapped. In 1965, the federal office reported that 135,000 handicapped persons had been successfully rehabilitated. This represented the combined production record of the 90 rehabilitation agencies of the United States.

As a result of the apparent large numbers of handicapped persons needing rehabilitation services and the projections made of 1970 and beyond, Congress passed Public Law 89-333 in 1965. A section of this law provided 100% funding of a limited cost and time basis so that each state could study the problems and needs of its handicapped and develop short and long range plans to provide adequate services to its handicapped citizens.

The Governor of Nebraska designated the Services for the Visually Impaired as the state agency to apply for the grant and to perform the statewide planning studies in Nebraska. The grant was approved on September 15, 1966.

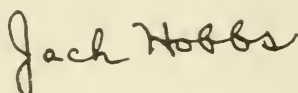
The purpose of the study was to plan a program which would insure the development of adequate rehabilitation services in the state so that all handicapped citizens that apply for services each year could be served immediately and adequately.

A target date was established with the statement that if all the plans were implemented successfully, then by the year 1975 any handicapped person who was found to be in need of rehabilitation services could be served without delay regardless of where this individual lived in the United States.

The report that follows is the result of a great deal of hard work on the part of the policy board, the advisory committee, and several hundred volunteers throughout the state as well as that of the personnel of the project office. These people worked diligently to prepare a report that would be factual and which would result in recommendations that would be sound and would have every chance of being implemented.

The Director would like to thank Mr. Herbert J. Larson, the Assistant Project Director, for all his endless hours of work and creativity. This thank you includes the fine clerical staff of the project office. A special tribute is given to the members of the Policy Board. The work of the regional chairman and their volunteers is appreciated beyond question.

The report is dedicated to the people of this state, especially the handicapped who have so much to contribute to society if only given the opportunity.

A handwritten signature in dark ink, reading "Jack Hobbs". The script is cursive and fluid, with the first letters of "Jack" and "Hobbs" being capitalized and prominent.

Jack Hobbs
Project Director

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S U M M A R Y R E P O R T

I. Purpose of the Study

On April 13, 1966, Governor Morrison appointed a Policy Board for the purpose of formulating a State Plan in Vocational Rehabilitation.

Five basic objectives were established for this project:

- 1) To identify by number and category the disabled within the State who are in need of vocational rehabilitation services; the identification to be made by means of sample studies of the handicapped population and the use of past studies of the handicapped population and the use of past studies and reports.
- 2) To prepare a written plan which will identify, analyze, and evaluate program goals, staff, and financial support needed to achieve these goals--with full geographic coverage by all programs offering vocational rehabilitation services. This will include planning for special facilities and workshops for the handicapped.
- 3) To identify the barriers that prevent or delay needed vocational rehabilitation services for the handicapped.
- 4) To identify vocational rehabilitation resources required to meet future needs, including the necessary legislative action, community support, costs, and steps required to facilitate the achievement of Statewide goals among the governmental and voluntary programs at state and local levels. These should be expressed in both interim and long-term goals.
- 5) To determine the ways in which governmental and voluntary programs may be coordinated and reorganized, if necessary, in developing services to meet more effectively the demonstrated needs.

II. Method Used and Sources of Information

1. The Policy Board considered that its basic assignment was to determine the extent and nature of the problem of handicapping conditions in the State of Nebraska and to estimate the number of disabled persons who were in need of and could benefit from vocational rehabilitation services.

Accordingly, a statewide survey was made with the use of a validated questionnaire using a 1.6% sample of the population. Approximately 24,240 persons were included in the sample.

2. A professional consultant from Oklahoma University was employed to take an inventory of vocational rehabilitation services in Nebraska and make a report.

3. Extensive interviews were held with officials of Services for the Visually Impaired and Division of Rehabilitation Services, scores of physicians, health departments, university educators, welfare directors, state institution directors, state senators, county officials, private social agencies and scores of citizens long interested and active in some aspect of vocational rehabilitation in the state.

4. A survey was made of the professional personnel, facilities and services available in Nebraska and an inventory made of those resources.

5. An analysis was made of all legislation dealing with vocational rehabilitation in Nebraska and allied resources for services to the handicapped in Nebraska.

6. Use was made of many official reports of Nebraska Vocational Rehabilitation and other states in this region.

III. Findings

The survey resulted in finding a total of 161,185 chronically disabled persons afflicted with 196,505 disabilities. An analysis of the characteristics of these disabled persons in accordance with Table I (page 4) suggested the possibility of limiting the total number of potential clients to a more realistic estimate. On the basis of age, the disabled under 16 and over 65 were eliminated reducing the number to 77,326. This total was further reduced by subtracting the number of disabled persons who indicated no appreciable limitation or whose disability apparently was compensated for by various physical devices or medical means. This left a balance of 61,858. A final reduction seemed warranted of persons whose disabilities were so severe as to make their vocational rehabilitation non-feasible. All of these eliminations, based on the reasons given, seemed justified in determining the minimum total of 50,709 individuals within the state who can benefit most from rehabilitation services. This core group will be referred to as the "Disabled Backlog," and is identified in the frame as outlined in Table I.

A more detailed analysis of the Disabled Backlog is given in Table II (page 6). The number in each disability category is given together with a tabulation of the extent of their limitation as stated by them and the distribution by age.

Those indicating psycho-social or academic problems as their chief limitation number 4,467 and make up 8.81% of the group. Sensory problems, affecting speech, hearing and visual areas, number 5,849 or 11.53%. The largest group are generally those that go unnoticed in the population since their disability is concealed. These are the persons having cardiac, respiratory, arthritic, digestive, endocrine, and metabolic disorders that

TABLE I

AGE VS. EXTENT OF LIMITATION - STATEWIDE CENSUS FINDINGS

Age	No Appreciable Limitation (1)	Compensated Medically Physically (2)	Academic Psycho-Social Psycho-Physical (3)	Visual Speech Hearing (4)	Definite Major Limitation Hidden Apparent (5) (6)	Profound (7)	Total (8)	
0-4	568	957	379	766	1,398	0	460	4,528
5-15	2,114	5,675	8,726	5,497	5,391	1,499	1,384	30,286
Preventive Rehab. Area - Total	2,682	6,632	9,105	6,263	6,789	1,499	1,844	34,814
16-25	747	1,007	3,635	136	4,123	253	1,699	11,600
26-35	895	2,281	309	483	4,668	763	1,460	10,859
36-45	460	1,827	262	2,286	4,160	975	2,269	12,239
46-55	1,311	3,729	127	1,685	8,193	2,649	2,820	20,514
56-65	1,030	2,181	134	1,258	11,966	2,644	2,901	22,114
Productive Age Range - Total	4,443	11,025	4,467	5,848	33,110	7,284	11,149	77,326
= 50,709 "Disabled Backlog"								
66-75	1,102	3,612	134	1,569	11,574	5,197	2,978	26,166
76-99	254	1,735	0	3,115	8,285	4,948	4,515	22,852
Retirement Age Range - Total	1,356	5,347	134	4,684	19,859	10,145	7,493	49,018

seriously limit their level of function. There are 33,110 persons in this group and comprise 65.29%. Disabilities readily apparent to the casual observer number 7,284 or 14.37% and are composed largely of those persons with gross orthopedic problems and amputations.

The age distribution shows that as people grow older the number of handicapping conditions increase proportionately. The sharp rise in the number of disabled after age 45 should be noted. It is apparent that this increase is due largely to a lack of earlier preventive rehabilitation service. It is fair to conclude that this number will greatly increase unless a more aggressive rehabilitation program is provided at an earlier age level.

It is further apparent that the present program is relatively ineffective in stemming the tide of the growing number of the chronically disabled when we compare the number of persons rehabilitated by category as reported in the 1966-67 Biennial report by both state services with the present backlog. We find only 2,079 or the equivalent of 4.1% of the "Disabled Backlog" successfully rehabilitated. The same report shows that 5,150 persons received some kind of service or approximately 11% of the "Disabled Backlog."

The increase in the number of disabled in need of rehabilitation services has been authoritatively estimated at 2½ to 3 persons per thousand annually or 3,750 to 4,500 persons in Nebraska (1). The present rate of rehabilitation services in Nebraska is reported to be at the rate of 1,039 per year or less than ⅓ of the new cases requiring such services. This is without reference to the backlog that currently exists.

(1) Voyle C. Scurlock's Report

TABLE 11

CHARACTERISTICS OF THE BACKLOG DISABLED

V.R.A. No.	DISABILITY	CHIEF LIMITATION				AGE DISTRIBUTION						
		TOTAL	PSYCHO-SOCIAL PSYCHO-PHYSICAL	VISUAL HEARING	HIDDEN	APPARENT	16-25	26-35	36-45	46-55	56-65	
1	Blind and Visually Impaired	4,151	--	3,867	284	--	268	251	1,140	1,237	1,255	
2	Hearing Impairment	1,521	--	1,292	229	--	--	458	609	306	148	
3	Orthopedic Impairment	15,769	--	113	10,005	5,651	1,514	1,611	3,216	4,915	4,513	
4	Amputees	886	--	--	151	735	229	380	--	126	151	
50-52	Psychiatric Disorders	3,256	1,933	64	1,126	133	1,816	332	--	842	266	
53	Mental Retardation	1,616	1,616	--	--	--	1,364	--	126	126	--	
60	Other Conditions Resulting From Neoplasms	879	--	--	879	--	--	--	380	364	135	
61	Allergic, Endocrine System, Metabolic and Nutritional Disease	5,610	767	--	4,843	--	1,471	1,651	217	1,144	1,127	
62	Diseases of Blood and Blood Forming Organs	458	--	--	458	--	229	--	--	299	--	
63	Epilepsy and Other Specified Disorders of the Nervous System	1,658	--	135	1,397	126	364	380	364	261	289	
64	Cardiac and Circulatory System	11,252	--	--	10,613	639	251	1,034	591	2,488	6,888	
65	Respiratory Diseases	1,602	--	--	1,602	--	--	--	528	387	687	
66	Disorders of the Digestive S 8 System	765	--	--	765	--	--	126	--	229	410	
67	Conditions of the Genito- Urinary System	135	--	--	135	--	135	--	--	--	--	
68	Speech Impairments	503	--	377	126	--	126	--	377	--	--	
69	Disabling Diseases and Condi- tions N. E. C.	497	--	--	497	--	299	--	135	--	135	
700	Social and Economic Deprivation	151	151	--	--	--	151	--	--	--	--	
TOTAL		50,709	4,467	5,848	33,110	7,284	8,147	6,225	7,625	12,654	16,035	
PER CENT		100.00	8.81%	11.53%	65.29%	14.37%	16.07%	12.27%	15.15%	24.95%	31.5%	

Nebraska per capita income compares favorably with the nation, but appropriation of state funds for rehabilitation has been falling down. While other states in the union increased appropriations 245% from 1955 to 1964, during this same decade, Nebraska increased its appropriation only 135%, ranking 45th in the nation(2).

Approximately 53% of the total funds that were expended for the vocational rehabilitation services were provided through third-party agreements. It is apparent that the state vocational rehabilitation agency has less than normal control of the total program. Inadequate funding has encouraged a proliferation of third-party agreements in order to further the state rehabilitation program. This practice, in turn, results in an imbalance of program with more service to some groups and relatively little to others (3). (See Table III, Page 8)

An analysis indicates that vocational rehabilitation is operating a limited, "traditional type" program, concentrating on the younger, and perhaps less difficult and less expensive client to the almost complete exclusion of certain segments of the disabled and dependent population, such as the public offender, older people, the alcoholic, and those requiring the services of rehabilitation and adjustment centers, and sheltered workshops. This is no doubt due, in part, to inadequate financial support (4).

Repeatedly, consistent wide-spread dissatisfaction has been expressed to the Policy Board concerning the present administration of the Division of Rehabilitation Services of Nebraska and with its placement under the State Department of Education. More specifically, complaints have been directed

(2) Ibid.

(3) Ibid.

(4) Ibid.

regarding the high turnover of staff, failure to adhere to high professional standards; inability to interpret its services, operations, and needs to state legislators as well as to the vast majority of citizens unfamiliar with rehabilitation services. It is suggested that all these factors have contributed to a woefully inadequate image.

TABLE III

PERCENTAGE OF BACKLOG
REHABILITATED, STATE OF NEBRASKA
1966-67 BIENNIUM

<u>DISABILITY</u>	<u>REHABILITATION REPORTED</u> <u>NEBRASKA 1966-67 BIENNIUM</u>		<u>BACKLOG</u> <u>DISABLED POPULATION</u>	
	<u>PERCENTAGE</u>	<u>NUMBER</u>	<u>PERCENT</u>	<u>NUMBER</u>
Orthopedic Impairments	28%	527	3.3%	15,769
Amputations	5%	86	9.7%	886
Hearing Impairments	8%	146	9.6%	1,521
Mental Illness	27%	503	15.1%	3,256
Mental Retardation	12%	214	13.2%	1,616
Heart & Circulatory Cond.	4%	74	.7%	11,252
Respiratory Diseases	1%	24	1.5%	1,602
Epilepsy - Other Neurological	3%	59	3.5%	1,658
Allergies, Diabetes, Endocrine	2%	40	.7%	5,610
Digestive System Disorders	2%	45	5.9%	765
Speech Impairments	2%	32	6.4%	503
Other Disabling Conditions	6%	109	5.1%	2,120
	100%	1,859	4.0%	46,558
Blind & Visually Impaired	10.6%	<u>220</u>	<u>5.3%</u>	<u>4,151</u>
		2,079	4.1%	50,709

IV. Observations and Conclusions

An effective vocational rehabilitation service has repeatedly and consistently demonstrated its social and economic value to the individual and society. It is fair to state that no other investment in human resources has resulted in greater returns. The social consequences, resulting in the change from futility, uselessness and dependency to self-support, independence and usefulness, is inestimable. The economic consequences to the rehabilitated individual have been documented as approximately 35 to 1⁽⁵⁾. It has been determined that for every tax dollar expended for vocational rehabilitation, there is a return of five dollars in federal tax payments and an additional amount returned in state taxes.

The need and potential for vocational rehabilitation and the justification for generous public support is readily apparent and pervasive. Environmental hazards contribute to an ever increasing number of handicapped persons in our highly industrialized society. The advance of medical science and resources results in persons with chronic disabilities living a longer life. A humanitarian and rational response to this increase in the handicapped population is a vigorous, effective policy and program of prevention and rehabilitation. The human spirit inspired with hope, combined with the great development in medical knowledge, has unlimited restorative possibilities which have scarcely been tapped. The philosophy underlying this assumption accepts the fact of individual blindness, of persons with only one or no limbs, or with an impaired heart, but refuses to recognize or accept permanent and total disability. Life, hope and usefulness are inseparable in a human progressive community. The acceptance of this principle therefore becomes the challenge of all who are committed "to making Nebraska a better place for all to live."

(5) Joseph Hunt, Commissioner, Rehabilitation Services Administration, "ACHTEVEMENT." September, 1968., op. cit., p. 1

The magnitude and scope of the problems of disability in Nebraska, as demonstrated from this inquiry, are both tragic and staggering. The physical, mental, emotional and behavioral disabilities with their related conditions of dependency, poverty, deprivation, and unemployment demand a commitment and constructive action on a scale heretofore non-existent. The limited efforts and resources made available to date are inexcusable and intolerable. A massive thrust now, both quantitatively and qualitatively, is required. This means not only greatly increased state appropriations, but wider knowledge and understanding of the nature and extent of the problem; increased communication between the Vocational Rehabilitation Department and the Legislature; more effective professional leadership and, finally, better co-ordination and utilization of all the private and public resources existing in the state.

Nebraska has been lagging far behind the nation in State Vocational Rehabilitation Services. The time is now to reverse this situation and initiate a progressive performance model for the rest of the country to imitate. The human and financial dividends are great, the investment assured, and the future made brighter for all our citizens.

V. Recommendations

1. It is recommended that the program and plan for Vocational Rehabilitation Services in Nebraska be revised to conform with the 1968 Federal Vocational Rehabilitation Act, Public Law 90-391 to provide services to all disabled and disadvantaged individuals.

2. The legislature appropriate adequate state funds in order to match all federal funds that can be effectively used by the State of Nebraska for Vocational Rehabilitation Services.

A. The above recommendation will require the direct supervision and administration of all services funded through the State Division of Rehabilitation Services.

B. Initiate legislative action or constitutional amendment to allow for use of Laird funds in State Rehabilitation Programs. This is imperative if total resources of federal government are to be utilized.

3. The evidence is overwhelming and conclusive that an immediate study of the total operation and administration of State Vocational Rehabilitation be made and its relationship to the State Department of Education. Reorganization is long overdue.

A. It would seem logical to consolidate the Division of Vocational Rehabilitation and Services for the Visually Impaired.

B. Serious consideration should be given to transferring the Division of Vocational Rehabilitation Services to the Department of Social Services as proposed by the Nebraska analysis Study Committee November, 1968.

4. It is of the utmost importance that adequate competent staff be made available. This will require progressive administrative policies for professional standards, equitable compensation and opportunities for promotion.

INTRODUCTION

In 1966, Governor Frank C. Morrison designated the Nebraska Services For the Visually Impaired as the state rehabilitation agency responsible for applying for a federal grant from the Vocational Rehabilitation Administration, a department of the federal office of Health, Education, and Welfare.

Congress had recognized the necessity of giving the state an opportunity to study their problems and needs in the entire field of vocational rehabilitation, and had appropriated funds up to \$100,000 per year so that each state could conduct such a project. The one hundred per cent federal funding for Statewide Planning for Rehabilitation Services was made available over a two year period and the grants were approved in the amount needed and documented by the individual state. The purpose of the Nebraska study was to develop a statewide plan which would provide the means of servicing every handicapped citizen in the state by 1975 who was determined to be in need of rehabilitation services. This goal was endorsed by the Governor.

The statutory provisions of the federal law providing for the funding of this study required that a Policy Board be appointed by the Governor. Its function was to provide guidance to the project staff and to determine the depth and scope of the study.

The Governor appointed a Policy Board who represented high level leadership from the fields of State Legislature, Labor, Management, Medical and Health Professions as well as Public and Voluntary Agencies. The names of the Policy Board members are listed on page 15 in the next chapter.

The Services for the Visually Impaired is located in the State Department of Institutions. It was designated as the Administrative Agency for the study and accepted the responsibility for the research.

The project staff was made up of five members. Its complement included the project director, the assistant project director, one secretary, and one and one half clerk typists. The project director served as secretary to the Executive Committee of the Policy Board.

The state was divided into fifteen regions coinciding with the (15) fifteen economic regions that had been determined by a study of the Extension Division of the University of Nebraska.

A chairman was named for each region who in turn selected a committee representing citizens from each county within the region. These regional committees proved invaluable in providing volunteers for the statewide census of the handicapped which was completed under the sponsorship of the project.

Research was completed by the project staff in the various phases of rehabilitation. The procedures that were utilized in this study included the development of an interview form designed to identify a

handicapped person living in a household; a statewide census which represented a 1.6 per cent sample of the population of Nebraska; questionnaires were developed and used to determine the various medical resources available in this state as well as auxiliary rehabilitation facilities. Another questionnaire covered the basic health service personnel who work with the handicapped of this state. A large number of face-to-face interviews were completed with the professionals who serve the handicapped in all of the various phases of rehabilitation. These interviews included public officials and the private citizen who had shown an awareness and interest in the rehabilitation programs of this state. The project director participated actively in the State Cooperative Area Manpower Program as well as various other governmental programs linked with state rehabilitation. Both professional members of the project staff served on the Committee for Rehabilitation Workshops and Facilities Planning of the Division of Rehabilitation Services.

The job of planning is very serious business, but the real need is to undertake the implementation of the recommendations as early as possible.

ORGANIZATIONAL CHART
STATEWIDE PLANNING
FOR
VOCATIONAL REHABILITATION SERVICES

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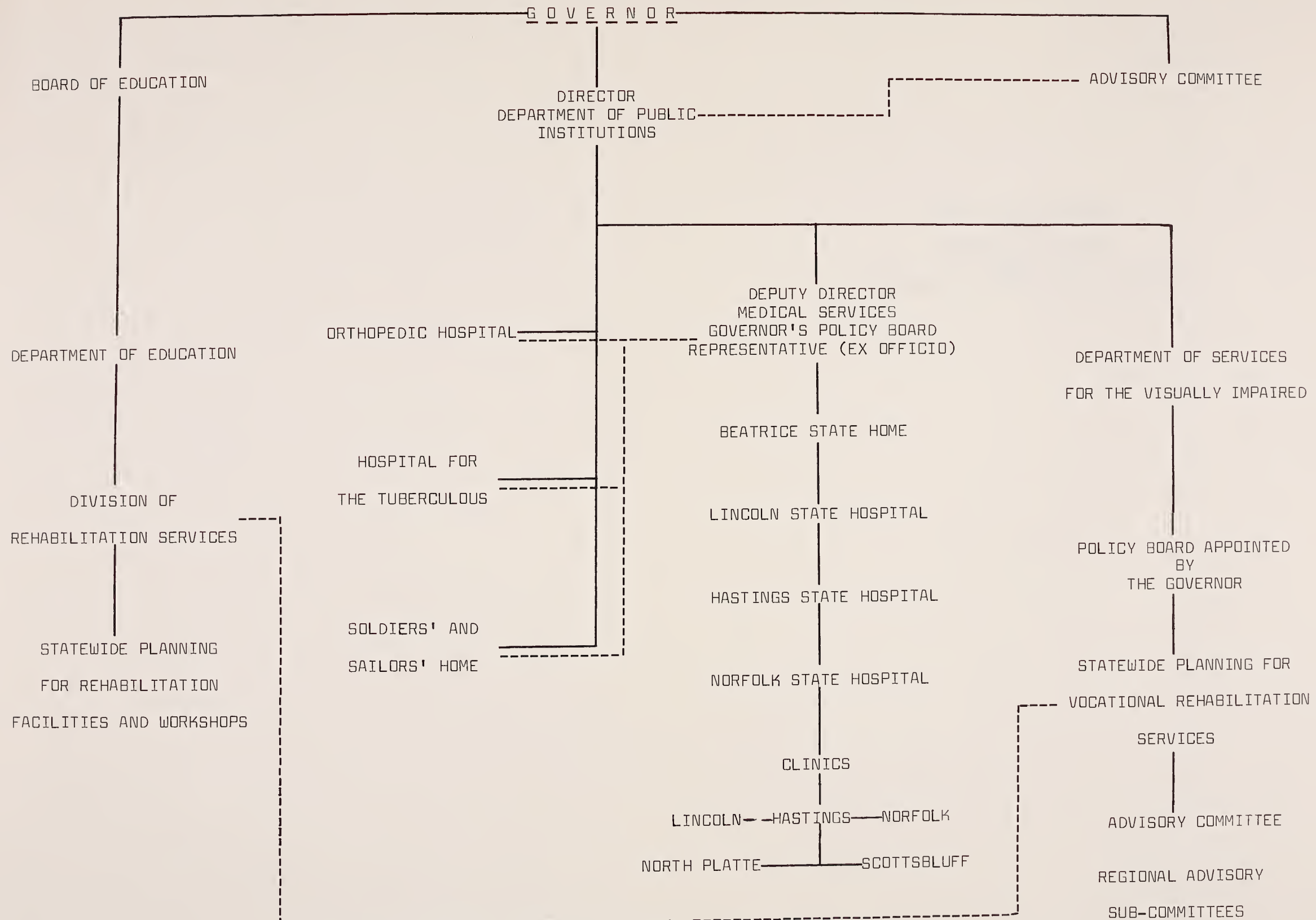
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ORGANIZATION
of
EXECUTIVE COMMITTEE
for
STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES
Rules and Regulations

1. Name: Executive Committee of the Statewide Planning for Vocational Rehabilitation Services project in the State of Nebraska.
2. Membership: The Executive Committee shall consist of five(5) members appointed by the Chairman of the Policy Board and membership drawn from the present Policy Board. Members are as follows:

Senator Calista C. Hughes	Marvin F. Oberg
Executive Committee Chairman	George W. Mechling
Philip H. Vogt	Leland C. Whipp
Executive Committee Vice chairman	Consultant
Richard W. Booth, M. D.	
3. Officers: The Chairman of the Executive Committee shall be the Chairman of the Policy Board.

Vice Chairman: Mr. Philip H. Vogt was elected at the first meeting to serve as the Vice chairman of the Executive Committee.

Recording Secretary: The Executive Committee asked Mr. Jack Hobbs, Project Director, to serve as the Recording Secretary. The Recording Secretary will keep the minutes of each meeting and will provide the minutes of the meeting to each Policy Board member and the Project office. When the Committee wants to discuss items without the presence of the Project Staff, a member of the Committee will serve as the Recording Secretary.
4. Meetings: The Executive Committee shall meet as the Chairman may determine, or upon petition of the majority of the members of the Committee.
 - a. Notice specifying the time, place, and the agenda of each meeting shall be mailed to each member of the Executive Committee within a reasonable time prior to the set meeting.
5. Quorum and Voting: A quorum group of the Executive Committee shall be three (3) members of the five (5) members of the Committee. The affirmative vote of the majority of the members present who are voting and those voting by proxy shall be required for the approval of any action.
 - a. An Executive Committee member may vote by proxy by giving the Chairman's written or oral instruction as to the manner the vote is to be cast.
6. Authority: The Executive Committee will act in behalf of the full Policy Board when it is not convenient to call a meeting of the entire Board.
 - a. The Executive Committee may refer any materials or matters of policy to the attention of the Policy Board for their decision.

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Region 1

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Region 10

Mrs. Anne Hahn
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Region 11

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Region 13

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Scottsbluff, Nebraska

Region 14

Mr. William Pick, Jr.
Hartington, Nebraska

Region 15

Mrs. Myron Clopine
Ainsworth, Nebraska

* Advisory committee was composed of the above listed 15 Regional Chairmen.



GENERAL FINDINGS

1. A census which was designed to identify the handicapped of this state was undertaken and completed by the project staff and several hundred volunteers. It included 1.6 per cent of the population of the state. It was determined that the average household size in this state was 3.2 persons.
2. The census finding of the project indicates that the incidence and prevalence rate for disabilities in Nebraska is 10.52 per cent.
3. The Nebraska census indicates that there are 161,158 Nebraskans of all ages who have chronic limitations of activity and mobility. Of this group, it is estimated that there are approximately 50,000 persons of employable age who are in need of rehabilitation services.
4. In 1968, the two Rehabilitation Agencies of this state served approximately 6,000 handicapped Nebraskans.
5. The 50,000 handicapped citizens who are unemployed and not enrolled in any rehabilitation program pose a serious economic and social problem for themselves, their families and the society in which they live.
6. Although the state has provided Rehabilitation Services for over forty-four years, the majority of the general public and the seriously handicapped are unaware that the state provides rehabilitation programs for the adult handicapped.
7. The Division of Rehabilitation Services has made it a policy to serve handicapped individuals in the order that they apply for services.
8. Records show that the Division of Rehabilitation Services has repeatedly run out of case service funds early during the second fiscal year of the biennium. This indicates that the agency has underestimated the number of clients it needs to serve during each funding period.
9. This has resulted in a situation wherein the agency has been unable to serve the handicapped who apply to the agency as new applicants.
10. The Division of Rehabilitation Services has been unable to serve new cases since August 16, 1968 when it placed a moratorium on its spending of funds on new cases.
11. This moratorium of services to new applicants will continue until July 1, 1969, unless a deficiency appropriation can be obtained from the state.
12. The Division of Rehabilitation Services continues to experience a very high turnover of its professional staff. This is extremely costly to the state as well as to the handicapped who are in need of vocational rehabilitation.

13. The Division of Rehabilitation Services, during the fiscal year 1968, served 379 persons per 100,000 population and rehabilitated 98 per 100,000 population. This earned respectively a national ranking of 26th and 27th position.
14. A consultant, nationally recognized as an expert in the rehabilitation field, was hired to review rehabilitation agencies of the state. He reported that by 1975, the state of Nebraska will need to rehabilitate from 3800 to 4500 persons per year.
15. This consultant reported that in order to accomplish the goal of successfully rehabilitating from 3800 to 4500 citizens each year by 1975, the state agencies should consider an expansion of staff. The general agency needs to plan an expansion of 3½ to 4 times its present operation.
16. The consultant noted that in 1966, the record showed that Nebraska ranked 50th in the nation in supporting Vocational Rehabilitation, with an expenditure per capita cost of .68¢. The national average was \$1.09.
17. Federal reports showed that in 1967 Nebraska ranked 37th and spent \$1.28 per capita expenditures for Vocational Rehabilitation. The national average was \$1.53.
18. In 1968, the General Agency reported the per capita expenditure was \$1.50. The national average cost and ranking information is not yet available.
19. The State Rehabilitation Agencies for Nebraska reported serving 5,108 handicapped Nebraskans during the fiscal year 1968. Of this number served, 1,267 were rehabilitated. The average cost per rehabilitation was \$1735.
20. It is reported that the combined annual earnings of all Nebraskans who were rehabilitated in 1968 was \$360,000.
21. The report from the consultant included an admonition that the Division of Rehabilitation Services could easily develop an unbalanced program due to inadequate funding. The agency has had to enter third party funding agreements through which the resources of two or more agencies are pooled in the interest of a common rehabilitation objective. The money that is represented is then used for matching federal monies.
22. During 1968, over 50% of the total funds, state and federal, used by the Division of Rehabilitation Services were earned by "third party" agreements.
23. Interviews with professional persons not employed by the state but vitally interested in the state rehabilitation program and the handicapped it serves have brought out the Statement that the Division of Rehabilitation Services has regularly received a smaller state allotment than has been considered desirable for the operation of its program.

24. Each six months, the Office of the Federal State Merit Systems of the Department of Health, Education, and Welfare publishes a report on state salary ranges. In the July 1, 1968 issue of this report, Nebraska ranked number (42) forty-second out of the fifty states and territories reporting in reference to top salaries paid to rehabilitation counselors.

25. This report listed the mean minimum salary paid to rehabilitation counselors as \$7180. The Nebraska Division of Rehabilitation Services was listed at \$6600 which is \$580 below the national mean. The Nebraska Services For The Visually Impaired was paying an entry salary of \$6060 for a new rehabilitation counselor with a Bachelors degree. This figure is \$1120 below the national mean.

26. This report listed the mean maximum salary paid nationally to rehabilitation counselors as \$10,913. The Nebraska Division of Rehabilitation Services listed a top salary of \$8500 which is \$2413 below the national mean, while the Nebraska Services For The Visually Impaired reported paying a top salary during this period of \$7764 or \$3149 below the national average.

27. The federal rehabilitation program divides the United States into nine regions. Nebraska is a part of Region VI. This region is composed of seven states which are contiguous. According to the State Merit System report, the states of Region VI supported their rehabilitation programs as follows:

	<u>Monthly Salary Range</u>	<u>Annual Salary Range</u>	<u>National Ranking</u>
Missouri	(700-916)	8400 -- 11,000	3
So. Dakota	(675-861)	8100 -- 10,332	10
Minnesota	(616-812)	7392 -- 9,744	15
*Iowa	(583-793)	7000 -- 9,520	19
No. Dakota	(500-755)	6000 -- 9,300	27
Nebraska	(550-680)	6600 -- 8,500	42
Kansas	(530-680)	6360 -- 8,160	45

28. An examination of the July 1, 1968 report on State Salary Ranges reflects that most states are adjusting the counselor's salaries upwards. Three states were paying a maximum salary in \$11,000 range, seven were paying more than \$10,000, and twenty-three were paying in the \$9,000 range.

29. A percentage of the counselors interviewed in Nebraska indicated that they wanted to make a career of their specialty field of counseling. They expressed the hope that the salary range could be set high enough to allow for the position of career counselor. It should be noted that not all counselors want to become administrators; however, many have stated that this is the only route that they can follow in this state in order to earn what they consider to be a reasonable annual income.

*It is understood that the salary for Counselor's holding Master's Degrees is considerably higher.

30. In the six month period from January 1, 1968 to July 1, 1968, the salary schedules for region VI rehabilitation counselors as reported by the Federal Office of the State Merit Systems reflected the following changes:

South Dakota..an Increase of \$924 per annum.	
North Dakota..an Increase of \$700 per annum.	
Missouri.....an Increase of \$500 per annum.	
Kansas.....an Increase of \$396 per annum.	
Minnesota.....No Change	\$000.
Nebraska.....No Change	\$000.
Iowa.....a Decrease of \$1000 per annum.*	

31. During the calendar year 1968, the Omaha District Office of the Nebraska Division of Rehabilitation Services experienced a very high attrition rate. The record showed that nine professional persons had held the position of rehabilitation counselor, but had left the work in the district office for various reasons.

32. The Omaha District Office of the Division of Rehabilitation Services is responsible for (5) five counties serving a population of approximately 450,000 persons. This office at the end of December, 1968, was serving 294 handicapped persons in referred status and 910 in active status or a total of 1204 persons.

33. During the fiscal year 1968, the Omaha District Office of the Division of Rehabilitation Services successfully rehabilitated 368 of the total 1265 reported by this agency. This production record represents (27) twenty-seven percent of the total rehabilitated.

34. The Omaha District Office of the Division of Rehabilitation Services is staffed by (1) one District Supervisor with approximately (3) three years rehabilitation experience and (2) two rehabilitation counselors with a combined experience in rehabilitation of two years and three months.

*This schedule probably pertains to Counselor's possessing the undergraduate degree.

35. There is a need to expand the rehabilitation services provided by the Division. This broadening of services is needed to reach certain categories of disabled and handicapped persons not now receiving services.

36. Communications need to be improved by the two state programs of rehabilitation in the following areas:

1. Between the two state programs of rehabilitation.
2. Between the two state programs and the power structure of the state.
3. Between the two state programs and the general public and the handicapped themselves.

37. The earlier that a handicapped person is identified, referred for state rehabilitation services, and then actually served, the better the total outcome has been found to be for the person being served.

38. Only a very small percentage of the population of this state know anything about the state rehabilitation programs; especially the eligibility requirements and the services provided by the state agencies.

39. Some professional persons mistakenly believe that a handicapped person must be indigent in order to qualify for state rehabilitation services. The law indicates that a handicapped person can be provided services if he meets the eligibility requirements established by the agency. A majority of services are provided without cost to the individual.

40. The Nebraska Division of Rehabilitation Services has repeatedly experienced fiscal problems that might have been prevented if this agency's bookkeeping section and the Director of the program had a prompt and reliable method of keeping track of the disbursements incurred by the agency. It took the agency from June 4, 1968 to August 16, 1968 to make a determination of its recent fiscal crisis.

41. The staff of the project office has completed a large number of interviews with State Rehabilitation Personnel, rehabilitation representatives from private agencies, representatives of other governmental programs, state senators, and private citizens who have exercised leadership roles in rehabilitation in this state. The majority declared strongly their displeasure with the Division of Rehabilitation Services. The three criticisms that were dominantly expressed were:

1. Dissatisfaction with the present administration of the agency.
2. Dissatisfaction with the placement of the agency under the State Department of Education.
3. Dissatisfaction with the inability of the agency to obtain what the majority of people interviewed considered to be a suitable and proper amount of money to operate the program.

42. The definition of rehabilitation continues to be expanded on the federal level which should result in larger numbers of the unemployed being provided services. The Division of Rehabilitation services continues to adjust its state plan as needed to serve these people.

43. Only a small percentage of the population of this state are knowledgeable about the services provided by the state rehabilitation programs. Therefore, a definition will be given in the findings. This definition is from a federal manual and states:

"Rehabilitation is a process of restoring the handicapped individual to the fullest physical, mental, social, vocational, and economic usefulness of which he is capable."

44. That state rehabilitation agencies are losing federal LaIRD monies due to Nebraska's constitution which prohibits the earmarking of funds going into the treasury of the state.

45. That a sizable number of counselors of the General Rehabilitation Agency of this state feel that the placement of the handicapped is not a part of the responsibility of their job.

46. That the services for the visually impaired have a placement man on the staff of their agency and the results have been most satisfactory.

47. A rapid turnover of counselors handling caseloads can be very disconcerting to a handicapped client. One of the offices of the Division of Rehabilitation services experienced a heavy attrition rate and at least one large caseload was turned over to a new counselor each four months.

48. The population density of Nebraska varies from less than one person per square mile to 1200 persons per square mile, with the heaviest concentration of persons populating the eastern part of the state.

49. This range from a very dense population in the eastern part of the state with the accompanying concentration of professional medical rehabilitation personnel and treatment facilities to a very sparse population in the western part of the state with a paucity of facilities and personnel creates a difficult problem in bringing rehabilitation effectively to all parts of the state.

50. Authorities in the field of rehabilitation, both from Nebraska and other states, have stated that medical and vocational rehabilitation service areas should be located so that no person will have to travel more than an hour to receive such needed services.

51. Nebraska is one of the (36) thirty-six states that have a separate state agency to serve the blind. The balance of the (18) eighteen states and territories have combined the blind agency with another state agency.

52. A majority of responsible people interviewed urged that the Division of Rehabilitation Services be relocated in State Government, and suggested it become a division of the Department of Social Services when it comes into existence.

53. Leaders of the majority of programs offering rehabilitation services in Nebraska as well as state and local rehabilitation committees have recognized a need for the creation of a new position in the State government of Nebraska. These people have recommended the creation of the position of Executive Secretary for the Employment of the Handicapped. The location of this position should be on the Governor's Staff with proper funding being provided.

54. It was difficult to find a breakdown of uniform geographical areas of the state that could be accepted by all the state agencies providing human services.

55. Each new governmental study that has come into existence in this state has divided the State into sections or regions to suit the needs of the individual study. This has resulted in confusion to the people trying to interpret the results.

56. When this study was begun in Nebraska, it was found that there existed no central repository for storage of studies that had been completed. It was felt that if a qualified state researcher could have maintained an office in which he reviews and digests information of a comprehensive nature that appeared to be important to Nebraska, that this would have been a tremendous help to this research and to various other programs of government needing such information.

57. It has been found that many professional people are having a very difficult time in keeping up with all the various new human services programs. It is difficult for the citizen in need of services to know where to go for help.

58. Disabled people and referring agencies have expressed a lack of confidence in the Division of Rehabilitation Services since it appears that the agency will be without funds to serve the handicapped for almost a year unless a deficiency appropriation is granted. The typical comment reported is: "Why make referrals or apply for services, they can't help you at this time."

RECOMMENDATIONS:

1. That the Nebraska Legislature fund the Division of Vocational Rehabilitation Services at least to the extent that programs for making vocational rehabilitation services available to:
 - (a) Any handicapped individuals who are under a physical or mental disability which constitutes a substantial handicap to employment, but which is of such a nature that vocational rehabilitation services may reasonably be expected to render the individual fit to engage in a gainful occupation.
 - (b) Individuals disadvantaged by reason of their youth or advanced age, low educational attainments, ethnic or cultural factors, or delinquency records, or other conditions which constitute a barrier to employment.
 - (c) Other members of their families when the provision of vocational rehabilitation services to family members is necessary for the rehabilitation of an individual described in Items (a) and (b) above.
 - (d) That funding for this purpose be such that the agency is enabled to make use of all federal funds available to the State of Nebraska for such purpose until such a time that the employment situation for all citizens of Nebraska no longer needs such comprehensive service for individuals.
2. That the State Plan of Operation for the Division of Rehabilitation Services be rewritten to allow for disadvantaged individuals to be served by the agency as well as those persons traditionally served by the agency. This is in accordance with the 1968 Federal Vocational Rehabilitation Act P.L. 90-391. This may require State legislation to include this group among those currently eligible to receive rehabilitation services. The federal definition of those eligible to receive rehabilitation is changing and the individuals who are now eligible have to be handicapped but not necessarily disabled to receive services.
3. That the Division of Rehabilitation Services do everything within its power to provide a stronger administrative program. This in turn will provide a better service program to the handicapped citizens it is charged to serve.

4. It is recommended that the Division of Rehabilitation Services follow the projected schedule:

	<u>Caseloads to be Served</u>	<u>Needed Professional Staff</u>
1969	6,385	46
1970	7,981	58
1971	9,976	72
1972	11,472	83
1973	13,193	96
1974	15,172	110
1975	17,448	126

5. That the salary schedules of the rehabilitation agencies of this state be brought up to competitive regional and national levels. The range from entry salary to highest salary paid should be increased so that there is room for advancement based on degree attained, proficiency in the job, longevity in service and degree of responsibility. An increased and more equitable salary schedule would attract the better and more qualified professional people to the rehabilitation counseling field in Nebraska. Recommend that this increase allow for maximum pay for the position of a career counselor.
6. That appropriate action be taken by the Legislature of the State of Nebraska to make it possible for the State Rehabilitation Agencies to use Laird monies in the operation of the rehabilitation programs. This may require a constitutional amendment in this State.
7. That a placement specialist be added to the state staff of the Division of Rehabilitation Services. It is recommended that the job responsibilities be statewide in nature and that the specialist train the professional staff of the agency in the techniques of placement.
8. That the Division of Rehabilitation Services encourage the establishment of transitional residential facilities in this state. One special need is proper housing for the retarded while they are undergoing work evaluation on vocational training in a facility such as Goodwill.
9. That an up-to-date case register of disabled persons be established in Nebraska. The information available from this center should be made available to all agencies of the state. Its development should be jointly planned and funded by all agencies carrying responsibility for the handicapped.
10. That both state rehabilitation agencies make concrete plans to assimilate statewide studies of the needs of the handicapped into their regular programs. Planning of this type is extremely important and should function out of the state office of the rehabilitation agency. It should be the fulltime responsibility of a qualified person and not added to the duties of another state office staff member. A reasonable budget should be provided for

this work so that it can be given proper time and flexibility in its operation. A possibility to be considered in this state is the possible joint funding of this work by both state rehabilitation agencies.

11. That the Division of Rehabilitation Services in the establishment of new third party agreements include as many other disability groups as possible to insure a balance of services to all disability groups.
12. That the Division of Rehabilitation Services plan carefully and limit the number of third party agreements that it will enter into in any designated period of time.
13. That the Division of Rehabilitation Services review its supervisory practices in all its third party agreements.
14. That the Division of Rehabilitation Services continue to plan its in-service training program very carefully and to use the maximum amount of state-federal money available for this purpose; that the planning of the in-service training truly meet the needs of the professional staff in their attempt to service the handicapped of the state.
15. That the Services for the Visually Impaired evaluate its in-service training program, identifying carefully the needs of its professional staff and listening to the staff as to what areas in which they need further training.
16. Recommend that in each of the district offices where a blind home teacher is assigned the office space be increased to provide three extra rooms for teaching space. One room should contain typical kitchen utilities, the second room bedroom and living room furniture, and the third outfitted as a combination conference room and training room. This recommendation would require that the state office for the Services for the Visually Impaired which also functions as a district office be provided more space or be located outside the Capitol Building. A third district office of this type with appropriate personnel should be located in the western half of the state.
17. That the State Rehabilitation agencies use the results of the Physicians Survey that was conducted by the Project Office in selecting medical consultants, resource persons for in-service training programs as well as establishing a sound referral system from this professional group.
18. That a directory of Rehabilitation Facilities be printed by one of the rehabilitation agencies of this state. All the information for this directory was obtained by the Project Office but funds were limited so the cost of the directory will have to be paid for by some other source.
19. That the Division of Rehabilitation Services add to its state office staff a good public relations specialist. One of the

basic findings has been that only a small percent of the population of this state know of the services of this agency. It should become wellknown and used regularly.

20. It is recommended that all Workmen's Compensation Insurance premiums paid by insurers of this state be used for the operation of the Workmen's Compensation Court but include a provision that the Court be allowed to use the funds for rehabilitation.
21. That a bill be introduced to the Nebraska Legislature providing the facilitation through the Workmen's Compensation Court of rehabilitation services. The bill should make provision that the injured worker be provided the best medical and vocational services available. This would include the services of public programs such as state rehabilitation or private services supported through private industry. The Compensation Court would have to provide close and conscientious supervision in the administration of this program.
22. That consideration be given by the two state rehabilitation agencies for the development of comprehensive evaluative services and workshops.
23. That as new counselors are trained and become proficient in their work, arrangements be made for their assignment to welfare offices or to the various educational service units throughout the state. This would provide valuable linkages as well as a more direct and continuous service to the handicapped of this state.
24. That the Division of Rehabilitation Services plan for the establishment of at least two or three additional offices throughout the state. They should be geographically located so they will serve a population that is found difficult to serve on a regular basis.
25. That the Services for the Visually Impaired expand its present operation by three times its present staff and present budget.
26. That the Visually Impaired agency as it expands its staff establish new district offices in each major geographical section of the state. In addition, that the agency give consideration to working out agreements with other governmental agencies who have offices representatively located throughout the state to stationing counselors on their premises full time to assure prompt referral and services to the blind and visually disabled of this state.
27. That both rehabilitation agencies routinely provide copies of the agencies' salary schedules to the professional members of its staff.
28. The registry for the blind should meet the standards of the Model Reporting for Blindness Statistics. Legislation should

be enacted which would allow the physician, the school authority, or a private institution to report any legally blind person or visually impaired individual who has been excluded from public or private services on the basis of their disability.

29. That the home teaching services of this state should be extended to all regions of the state.
30. That Nebraska needs at least four additional workshops to serve the handicapped. They should be co-sponsored by the community and the Division of Rehabilitation Services. They should be located in the areas of the state where they could serve the people of that region. Suggested locations would be Scottsbluff, North Platte and Grand Island.
31. That the Division of Rehabilitation Services should provide specialized counselors in working with the deaf. These people should be proficient in deaf communication and placement of the deaf.
32. Establish a vital statistics section of the Division of Rehabilitation Services and develop a system wherein severe disability cases can be systematically recorded. This would help provide preventive programs and early service.
33. That the Division of Rehabilitation Services seriously investigate the possibility of establishing a homebound industries program.
34. That the Division of Rehabilitation Services investigate the possibility of instituting a computer program so that record keeping and fiscal controls can be made easier and more productive.
35. That the Division of Rehabilitation Services strive to help in the establishment of additional halfway houses and transitional living facilities for those clients of the psycho-social classification. The agency should seek the help of the resources already existing in the various communities. The Division of Rehabilitation Services should, in its attempt to coordinate the planning of such facilities, give prime consideration to the involvement of the citizens of the community as well as including the participation from the following programs: Department of Institutions, Welfare, Department of Labor, Services for the Visually Impaired, and private programs such as Goodwill and the Salvation Army.
36. That the Division of Rehabilitation Services and the Services for the Visually Impaired participate in a strong in-service training program with the Nebraska Psychiatric Institute so that more counselors can be trained to deal with psychiatric cases. The training could be short-termed which would allow counselors from each section of the state to participate. Persons from related programs should be included in the training. This would allow for the training of more staff in handling psychiatric problems as well as establishing better linkages between programs.

37. That consideration be given by the Director of the Services for the Visually Impaired to liberalize the college training provision for the professional staff and provide the opportunity for the staff member to enroll in a three-hour course at university level during working hours. (This would allow for an up-grading of the staff member and provide better professional services to the blind of this state.)
38. That the Services for the Visually Impaired should have a minimum of (1)one counselor, (1)one home teacher, (1)one supervisor of special services, and (1)one full-time secretary to staff the western office of the state.
39. That the Services for the Visually Impaired transfer the Ogallala office to North Platte, Nebraska. Consideration should be given to the establishment of an office in Scottsbluff, Nebraska.
40. That staff members working in the capacity of District Supervisors be given this title and full authority to function in this capacity.
41. That a time study be completed on all the offices of the Services for the Visually Impaired. This study should cover the activities of the professional and the clerical staff alike.
42. That the vending stands that are now being controlled by the Service for the Visually Impaired be supervised only by the professional person or persons designated this responsibility by the agency.
43. That the operators of the vending stands keep their own books subject to audit by the staff of the agency. This would allow for the elimination of one accounting clerk from the state staff of the Services for the Visually Impaired.
44. Working agreements be established with those high schools having a sufficient number of handicapped students warranting a special education teacher on the staff in the form of third party agreement.
 - (a) Counselors employed for this purpose should possess an educational background equivalent to that of requirements of the general rehabilitation services.
 - (b) The Counselor should be responsible to the District Supervisor of his area, and his work and case-load regularly reviewed as a check on efficient operation. Since the financing for the programs comes largely from the rehabilitation budget, this should be an accepted procedure.
 - (c) The Professional Staff of the Division of Rehabilitation Services should enjoy the same status in the education system as accorded other professional personnel. Within the province of his expertise, the counselor should be consulted with regard to the vocational training of every handicapped child in the school. He should work closely with all specialists provided by the school (speech and hearing, school psychologist, and other related personnel) in order to effectively coordinate their efforts on

behalf of the handicapped child. He should be alert to the more serious manifestations of mental problems or physical disorders so that proper specialists can be obtained for the most serious problems.

(d) Services needed for the handicapped child, over and beyond those provided by the school should be paid for out of the matching third party funds to insure that all necessary services are obtained.

(e) The counselor's caseload would be composed of every child who applies for preventive rehabilitation services through the parents' initiative, providing he meets the qualifications for eligibility as provided by the Rehabilitation Act. The State Plan for the Division of Rehabilitation Services should be amended accordingly.

(f) In the beginning it would be advisable to limit services to those students of high school age only and extend the services of the organization to the lower grades as funds and acquisition of qualified personnel permit.

(g) Performance of the counselor would be judged on the basis of his ability to coordinate activities of the available professional personnel. To fulfill the needs of the client, the effectiveness will be demonstrated by future successful rehabilitations obtained by cooperating state counselors. The counselor must be able to ultimately extend and expand rehabilitation services to all handicapped persons of the elementary and secondary level.

DIVISION OF REHABILITATION SERVICES

In Nebraska, the Division of Rehabilitation Services is a Division of the State Department of Education. Mr. Fred A. Novak is the appointee of the Commissioner of Education and serves as the Assistant Commissioner of Education and Director of the Division of Rehabilitation Services.

The Division of Rehabilitation Services is a public service program which exists for the purpose of providing vocational rehabilitation services to handicapped individuals in order to render them fit to engage in gainful occupations commensurate with their overall potential.

The agency serves any resident of Nebraska who is near employable age and who meets the eligibility requirement of having a disability that constitutes a substantial employment handicap and who it is determined can become employable through Rehabilitation Services within a reasonable length of time.

The agency provides a special evaluation for individuals for whom it is not possible to determine (at time of referral) whether or not they can become employable through Rehabilitation Services within a reasonable length of time may be accepted for necessary vocational rehabilitation services during an extended evaluation period of from 6 to 18 months.

In order to reduce a handicapping condition or to provide compensating skills, the following services are provided to the handicapped clients as needed:

1. Medical and vocational diagnosis to determine extent of disability and work capacity.
2. Individual counseling and guidance to help the disabled person select the right job.
3. Medical, surgical, psychiatric treatment and hospital care to help bring back or improve the person's ability to work.
4. Prosthetic appliances such as limbs, braces, hearing aids and glasses to fulfill the need for physical aids.
5. Training to develop job skills in schools, on-the-job, by correspondence or by tutoring.
6. Financial assistance with costs of living expenses, books and transportation during training.
7. Financial assistance with occupational tools, initial stocks and licenses when ready for work.
8. Placement assistance in finding and adjusting to a suitable job.

The services of this agency are provided through the professional staff. The agency maintains a state office, a disability determinations section, has five general district offices, ten vocational

rehabilitation units and staff stationed at various state mental hospitals and mental health clinics, two offices in welfare settings, one mobile home unit, one office at Girls' Town, schools, and one State Workmen's Compensation Court.

The staff complement of this agency is composed of 143 people. This breaks down to 123 full-time, of which 60 are classified as professional, 6 aides, and 57 clerical. Twenty(20) medical people serve as part-time consultants to the various departments. The program is funded on a share-cost basis. During the last fiscal year the funds were based on 25% state and 75% federal. During the fiscal year, 1969, this ratio changes with the state providing 20% and the federal providing 80%. More detailed figures concerning budget will be discussed elsewhere in this report.

Rehabilitation nationwide is big business. Rehabilitation was established by law on the federal level in 1920. The State of Nebraska established its rehabilitation program in 1921. It has always been a program that has been described as having a heart and a tremendous "know-how". This "know-how" is described more academically as the Rehabilitation Process. It has been demonstrated repeatedly that if the process is followed, it usually results in a successful rehabilitation. The services are normally provided only once to a client and the expenses are minimal. The rate of return of old clients in Nebraska for services has been estimated to be about 5% or less. However, it is recognized that in the case of the retarded or the very severely disabled the probability is that they will have to be served more than once in a several year period.

State Department of Education
DIVISION OF REHABILITATION SERVICES

Standards

Qualifications, duties, and responsibilities of positions

All personnel shall possess physical stamina, initiative, resourcefulness, persistence, adaptability, maturity of judgment, emotional stability, and the ability to work with others. Supervisors shall have, in addition, the ability to train others in their duties, to evaluate their work, to devise and apply remedial measures when necessary, and to inspire confidence of others.

COUNSELOR

Graduation from a four-year college or university, or its equivalent, and no less than three years of recent full-time experience in the following fields: vocational rehabilitation, education, personnel work, welfare or employment service.

The Counselor is directly responsible to the District Supervisor in whose district he is assigned. His combined functions are those of case investigator, caseworker, vocational counselor, training supervisor, and placement officer. It will be his duty to carry out all phases of rehabilitation services which are appropriate for potential and active cases in his jurisdiction. Examples of work performed include determination from medical reports and other information the applicant's eligibility for services, counseling to enable the client to select suitable vocational objectives, formulation of rehabilitation plan with client for provision of appropriate services such as physical restoration, training, job placement, and other auxiliary services. In addition, he is responsible for such developmental activities within the district as are necessary in maintaining an adequate caseload.

DISTRICT SUPERVISOR

Same as for Counselor and, in addition, must have demonstrated by two or more years of casework or technical experience in vocational rehabilitation, or by one year of such experience and additional specialized training, that he possesses the abilities to perform the duties outlined for this position.

The District Supervisor is directly responsible to the Assistant Directors and has complete charge of rehabilitation casework within an assigned geographic district. He may work alone within the designated area doing all case service field work and developmental activities himself, or he may have counselors and other workers assigned to assist him, in which case he will also

be responsible for the proper direction and results of their activities. His duties are: (1) development of, and service to, an adequate caseload in his assigned territory; (2) development of, and proper functioning of, working relationships with other agencies; and (3) presentation and interpretation of policies and procedures for the conduct of vocational rehabilitation to clients, to employers, and to the general public through both individual and group contacts.

COORDINATOR-COUNSELOR

Same as for Counselor and, in addition, must possess skills in the area of medical consultation work or in the area of medical social work.

SUPERVISOR, DISABILITY DETERMINATIONS

Qualifications are the same as for Counselor. The person so engaged has responsibilities for evaluating evidence in case files, securing additional medical evidence or other information where necessary to make a determination, authorizing additional medical examinations for purposes of verification when deemed necessary, and in general, the regular team cooperation with the reviewing physician in making disability determinations. In addition to this, his work shall include formulating general procedures in case processing, arranging for and conducting conferences where training is needed, establishing cooperative working relationships with other agencies, fostering mutual understanding with physicians and other related professional groups, and preparing budget requests, financial and statistical reports which are required and necessary for good administration. In addition, is directly responsible to the Assistant Commissioner-Director for Rehabilitation Services in matters of directing and coordinating the work of the Disability Examiners, medical consultants and clerical staff.

DISABILITY EXAMINER

Qualifications are the same as for Counselor. The nonmedical member of the State review team who serves with the State review physicians in evaluating all case data in the application file received from the CASI District Offices. He has primary responsibility for considering the work history, employment record, capacities and other facts relating to the applicant necessary to reach a finding of inability to engage in substantial gainful activity. He examines and evaluates all evidence included, secures additional data where deemed necessary, consults with applicants and others concerned, and finally writes the summary of data used in arriving at a determination.

ASSISTANT DIRECTORS

Must possess the same educational qualifications as a Counselor, plus not less than nine hours of graduate credit. Shall possess ability to survey and evaluate operating situations and exercise

good judgment in developing new policies and procedures for the efficient operation of the program and for insuring the maintenance of acceptable standards in the quality of case services rendered. In addition, he must have demonstrated leadership ability in supervision or administration.

The Assistant Directors shall: (1)assist and instruct counselors in casework procedures and techniques and make recommendations with respect to the adoption of new casework policies; (2)examine and approve all rehabilitation plans according to established policies of case selection and case service; (3)review cases and recommend closures; and (4)develop and maintain uniformity in case service practices and participate with other administrative, supervisory, and consultant personnel in the general program of staff development.

ASSISTANT COMMISSIONER-STATE DIRECTOR

Same as for Assistant Director and, in addition, must possess the following: (1)the ability to enlist, organize, and use effectively the cooperative effort of others, including co-workers, agencies, groups, and individuals, and to retain their loyalty; (2)the ability to anticipate, analyze and make plans for meeting needs and situations; (3)the ability to manage funds and personnel efficiently, the ability to train subordinates in their duties, to analyze and evaluate their work, and to devise and apply remedial measures when necessary.

The Assistant Commissioner-Director shall: (1)provide promotion, organization, and general supervision of the program and its operation and management of personnel; (2)prepare standards for the determination of economic need, general standards and arrangements for surgery, hospitalization, and prostheses, case finding methods, and referral procedure and agreements; (3)investigate qualifications of applicants for positions and make recommendations respecting the employment of personnel; (4)arrange for and conduct in-service and up-grading training of personnel and supervision of personnel to insure that proper technique, methods, standards, quality and quantity of case service are maintained; and (5)maintain adequate statistical and financial reports and make such reports to the Assistant Commissioner for the Vocational Rehabilitation Administration as may be required and consistent with Plan provisions; and (6)the Assistant Commissioner-Director's duties with respect to the determination of disability for CASI will be limited to the overall administration of the program.

STATE MEDICAL CONSULTANT

and

DISTRICT MEDICAL CONSULTANT

Graduation from a school of medicine approved by the Council on Medical Education and Hospitals of the American Medical Association, licensed to practice medicine and surgery in the State, and at least three years of resident or graduate training or

experience in a medical field appropriate to physical restoration.

The State Medical Consultant shall: (1)advise the Assistant Commissioner-Director in matters of general policy in regard to physical restoration and diagnostic procedures; (2)participate in training of the counseling staff with regard to physical restoration and diagnostic procedures; (3)recommend standards for selection of physicians and medical facilities, and (4)assist in determining rates of payment for medical services.

The District Medical Consultant shall: (1)furnish consultation to counselors on individual cases and specific medical problems; (2)advise on the need for, or desirability of, special diagnostic examinations, and (3)review reports of examining physicians and advise the counselor regarding specific recommendations for physical restoration.

Applicants for professional positions who have Masters Degrees are given preference.

The qualifications, classification, duties and schedule of compensation currently in force for the clerical personnel in the State Department of Education-Division of Rehabilitation Services are observed by the Division of Rehabilitation Services. This schedule was approved by the Commissioner of Education July 1, 1962. This was revised and approved July 1, 1962.

IN-SERVICE TRAINING PROGRAMS PROVIDED BY THE GENERAL AGENCY

Mr. Thomas O. True is the assistant director for the Division of Rehabilitation Services. Included in his responsibilities is the task of planning and implementing in-service training for the entire staff of the general agency. Authorities in the rehabilitation field have offered opinions on the length of time it takes a new untrained rehabilitation counselor to reach his maximum effectiveness in his work after he joins a rehabilitation staff. Some experts feel that it takes approximately 3 years to accomplish this and an investment equal to about \$18,000 to adequately train a professional person on a rehabilitation staff. No one in Nebraska has really offered concrete information as to what the cost factor is in training a Nebraska rehabilitation counselor but it is suspected that the time period mentioned above and the cost factor referred to are probably true for this State.

In the past two years various members of the staff of the rehabilitation program have been asked about the in-service training program that is offered by the Division of Rehabilitation Services. In-service training is a planned program which is designed to orient new members that join the rehabilitation staff whether they be professional or clerical, as well as to provide the existing staff with continuous training to keep them abreast of procedures, techniques, new laws, and to generally upgrade their work in the rehabilitation setting. A fairly high percent of the persons that answered questions about the in-service training program provided by the Division of Rehabilitation Services were rather critical about the program, particularly the training that is offered to new counselors. Mr. Scurlock, the consultant from Oklahoma, had also been critical of this training. A meeting was recently held with Mr. True since he carries the responsibility for all phases of in-service training for the Division of Rehabilitation Services. Some points will be made that are a result of this meeting.

The general agency will have approximately \$3,079 to spend on its in-service training program. This money is made available on a ratio of 90% being provided by the federal government and 10% by the state. To qualify for the federal money the state must outline rather carefully its plan for the fiscal year on what types of in-service training will be provided. Mr. True recently prepared a questionnaire which was sent to the professional staff of the general agency in which he asked that the staff react to the in-service training programs that have been provided and in what areas training could be provided that would be meaningful to them. He has made an analysis of the returns and has thus been able to plan training programs that will meet the needs as expressed by the staff members. This allows him to set a priority as to what training programs will be given priority this year as well as to set up training programs over the next several years. Of course this program is subject to change as needs arise within the agency.

It was found that Mr. True was knowledgeable of the criticisms that had been made about the new counsellor orientation programs.

The 3-M Company of Minnesota for the past several years has been working very closely with the rehabilitation agencies in every state in the

United States. They have developed audio-visual packets, which include an introduction to rehabilitation prepared by Mr. John McGowan of the University of Missouri, that can be used for counsellor orientation training. The state office now has these available and is using them as new members are brought onto the staff. Although a period of four full days is provided a new staff member for this orientation, Mr. True feels that this is insufficient and that to be effective, the program of orientation and in-service training has to be continued from the district office level. It is the intent that the Rehabilitation Service units and each of the district offices with the exception of Scottsbluff, which is a one man office, be provided with overhead projectors and in-service training packages which can be used in a training program in the district. It was pointed out that most of the district offices carry on an in-service training program at least once a week. This training is the responsibility of the district supervisors and although they follow any program that Mr. True provides for them, the district office training program is flexible enough to try to provide training that will answer some of the current problems facing rehabilitation counsellors day-by-day. For example, in the Omaha district office Dr. Bulent Tunakan, the psychiatric consultant for the district, used to spend at least one hour each month with the professional staff to discuss problems of a psychiatric type that the professional staff had requested. This helped to give the staff a better understanding of psychiatric dynamics.

Some of the activities that the professional staff of the general agency will participate in this year as part of the in-training service programs are:

The College of St. Thomas of St. Paul, Minnesota, through a federal grant, will be providing management training courses throughout various regions of the United States. Regional stipends for a selected few are available this year.

Each year prosthetic orientation training has been provided for a few members of the professional staff. They have received this training at the Rehabilitation Institute of Chicago. This training is still available to the State of Nebraska but the state must now pay for travel costs and per diem of any counselor that attends the course. The state agency had originally reserved ten slots for this training but it has had to give up this reservation and will send fewer for this training.

Management training has been offered through the Vocational Rehabilitation Management Training, Extension Division, at the University of Oklahoma at Norman, Oklahoma. This training has been attended by members of the staff who hold key positions.

An Institute on Rehabilitation Services will be held in 1969 at the Kellogg Center in Lincoln, Nebraska. It is anticipated that several persons from the state office staff of the program will attend.

Normally the Division of Rehabilitation Services and the Services for the Visually Impaired agencies have collaborated in planning joint meetings where in-service training is provided in conjunction with the

state staff meetings. The Division of Rehabilitation Services program has for several years held a clerical staff meeting which usually involves one full day of in-session time combined with a tour of a rehabilitation facility, plus the time it takes to travel to and from the meeting. The purpose of the clerical staff meeting is to give the staff an opportunity to get acquainted with each other, to alert the staff members to new changes taking place in the state program, new changes in rehabilitation legislation, over all goals of the agency, to clarify reporting procedures and the use of new forms. Several states have used this approach and since the rehabilitation effort is a team effort, it is expected that this type of meeting pays for itself by reinforcing the team concept and probably results in a more conscientious, dedicated clerical person working the rehabilitation offices throughout the state. When these clerical meetings are held the professional staff maintains a skeleton crew in the offices so that the work of the offices can be continued without interruption.

Recently a questionnaire was sent by the project office to the various people throughout the State of Nebraska who are either working in a rehabilitation setting or are in some way professionally involved in the rehabilitation process. Mr. True has asked that part of the information from this questionnaire be made available to his office so that he can be alert in identifying the needs in the in-service training area and plan programs that will be acceptable and give direction and training to the entire staff of each rehabilitation office in the state.

Mr. True has indicated that each rehabilitation office spends about 5% of its time each month on in-service training.

RECOMMENDATION: That the Division of Rehabilitation Services continue to plan its in-service training program very carefully and to use the maximum amount of state-federal money available for this purpose; that the planning of the in-service training truly meet the needs of the professional staff in their attempt to service the handicapped of the state.

PRODUCTION RECORD OF
DIVISION OF REHABILITATION SERVICES

During the period involving the fiscal years 1961 through 1968, the Division of Rehabilitation Services accepted 9,810 new cases for services. In this same period, they served 25, 576 handicapped Nebraskans and rehabilitated 6,234 handicapped individuals. The mean cost per rehabilitation based on Section 2 expenditures for this 8 year period was \$1,035. The range of the cost per rehabilitation was \$696 to \$1,735.

The U. S. Department of Health, Education and Welfare, through the Social and Rehabilitation Service, Rehabilitation Services Administration, publishes various types of program data concerning the State Rehabilitation Agencies.

Many of the tables that are referred to in this section have been prepared from various reports published over a several year period by the federal agency. Most of the data is complete through the fiscal year ending June 30, 1967. However, the federal office had not published the statistics on Nebraska for the fiscal year 1968 at the time this report was prepared but whenever possible the information known for fiscal 1968 has been presented in the tables.

Table 1 on page 65, delineates the growth pattern of the cases being served by the Division of Rehabilitation Services in Nebraska. In January 1968, Mr. Voyle Scurlock, a rehabilitation expert from the University of Oklahoma, made the following recommendations in his consultant report: "In order for Nebraska to have an 'adequate' program by 1975, it will be necessary to expand its present services by three and a half to four times its present operation."¹

He had presented facts in his report in which he showed there is an estimated backlog of 30,000 Nebraskans that are in need of the services provided by the two state rehabilitation agencies. His statistics indicated that the state services in 1967 had reduced the backlog by only 4%. One of his expressed concerns was that unless these people are served adequately the tremendous cost of dependency will continue to grow and the dependency cycle will not be broken.

He pointed out that the state funds that have been appropriated for this program have been inadequate in meeting the real and total rehabilitation needs of the handicapped of this state. He recommended that a budget be prepared which would be realistic in attempting to serve all the handicapped of this state who are in need of services. He pointed out that the figures might seem staggering but that the decision-making authorities of this state need to really

¹Voyle Scurlock's Report. See Appendix

comprehend the magnitude of the problem. If the agency could be properly funded and staffed, then the large backlog of the handicapped could be reduced and the newly handicapped each year could be served promptly and efficiently.

A review of the production record and the expenditures incurred by the Division of Rehabilitation Services is presented in the following table:

D. R. S. GROWTH PATTERN 1962-1968

	<u>Percentage Caseload Increased</u>	<u>Percentage Increase in Rehabilitations</u>	<u>Counseling Man Years</u>	<u>Cost Per Rehabilitation</u>	<u>Percentage Cost Increase</u>
1968	14	11	33.1	\$1735	18
1967	21	12	29.8	1432	32
1966	13	22	20.8	979	15
1965	11	11	16.2	839	-7
1964	5	16	12.1	897	4
1963	1	-15	10.8	865	24
1962	5	11	16.3	696	-20

Another method of estimating costs and trends is to multiply the total rehabilitations in a year by the cost per rehabilitation and the resulting figure gives an index to the amount of case service monies spent in that year.

	<u>Number Rehabilitated</u>		<u>Cost</u>		<u>Case Service Money</u>
1968	1267	x	\$1735	=	\$2,198,245
1967	1037	x	1432	=	1,484,984
1966	822	x	979	=	804,738
1965	724	x	839	=	607,436
1964	639	x	897	=	573,183
1963	541	x	865	=	467,965
1962	634	x	696	=	441,264
1961	570	x	839	=	478,230

During this seven year period the agency experienced:

1. a mean annual increase of 10 per cent in the caseload,
2. a mean annual increase of 9.71 per cent in the number of rehabilitations,
3. a doubling in the size of the staff, and
4. the cost per rehabilitation increased 1½ times while the mean percentage cost increase was 9 per cent.

Routinely the agency has expended its funds before the end of the biennium. The reason for this occurrence is that the agency has either underestimated its budgetary needs or has been funded inadequately. In all probability, it is a combination of both factors.

An attempt has been made to project the budgetary needs of the Division of Rehabilitation Services for the period 1969 through 1975. This projection is conservative since its design provides for the agency to be serving 17,448 handicapped Nebraskans by 1975. It should be realized that the Services for the Visually Impaired normally serves about ten per cent of the number listed by the general agency. An estimate of 1,745 cases can be listed for the Services for the Visually Impaired. Thus a combined total of 19,193 cases should be receiving services by 1975.

The report by the Nebraska Management Analysis Study Committee recommends the establishment of a Department of Social Services within the government of this state. This proposed organization would provide for a Director and seven(7) Divisions. The proposed divisions are as follows:

- (1) Business Administration Services
- (2) Division of Health
- (3) Division of Welfare
- (4) Division of Vocational Rehabilitation
- (5) Division of Mental Health and Retardation
- (6) Division of Correctional Services
- (7) Division of Special Institutional Services

If this department is created, there is a strong possibility that an additional number of the handicapped would be directly served through one or more of the other divisions viz. Mental Health and Retardation.

Legislation Bill 203 is a Rehabilitation Proposal that is currently being considered by the Nebraska Legislature. It would permit the Nebraska Workmen's Compensation Court to establish a vocational rehabilitation program for workers injured on the job. If this bill becomes law, it would create another resource in the provision of early services to the handicapped. This should aid in making certain that the disabled backlog is decreased appropriately and the newly disabled served adequately.

The Division of Rehabilitation Services will need to increase their general counseling staff according to the following schedule:

<u>YEAR</u>	<u>COUNSELORS</u>	<u>% INCR.</u>	<u>APPROXIMATE CASELOAD</u>	<u>AVERAGE SIZE N ACTIVE CASELOAD</u>	<u>EXPECTED CLOSURES</u>
1969	46	14	6,385	138	1596
1970	58	12	7,981	138	1995
1971	72	14	9,976	138	2494
1972	83	11	11,472	138	2868
1973	96	13	13,193	138	3298
1974	110	14	15,172	138	3793
1975	126	16	17,448	138	4362

The following table represents the minimum amount that the state should fund the Division of Rehabilitation Services for the next seven years. If the state will accept this growth schedule, it will provide the handicapped a proper service and help reduce the large backlog of disabled people now needing services.

PROJECTED BUDGETARY NEED FOR D. R. S.

<u>YEAR</u>		<u>FEDERAL</u>	<u>STATE</u>	<u>TO SERVE HANDICAPPED CASELOAD</u>	<u>EXPECTED CLOSURES</u>
1969	\$ 3,325,000	2,902,000	322,500	6,385	1596
1970	4,983,510	4,485,159	498,351	7,981	1995
1971	7,482,000	4,036,644	448,515	9,976	2494
1972	8,776,800	7,021,440	1,755,360	11,472	2868
1973	13,891,176	11,112,941	2,778,235	13,193	3298
1974	18,373,292	14,698,634	3,674,658	15,172	3793
1975	24,300,702	19,440,562	4,860,014	17,448	4362

Please note that Table 1, page 65, shows that in an 8 year period the number of handicapped persons that have been served by the general agency has increased more than 100%. This has required a doubling of the size of the staff and an increase in expenditures to accomplish this goal.

The last column in Table 1 shows the average cost per rehabilitation in Nebraska. The average cost is relatively inexpensive when considering the types of cases that are served and the range of time that is involved in the various cases.

Table 3 on page 66 lists the average cost per rehabilitation for a nine(9) year period. Nebraska's average cost is consistently lower year after year than the national mean. It is important to notice that the average cost per rehabilitation continues to grow each year. The agency has experienced a substantial increase in medical costs and training costs.

Many figures have been offered by authorities in the rehabilitation field as to what monetary return the state and the federal government derive from each successful rehabilitated client. A comprehensive report called Cost-Benefits Analysis of Vocational Rehabilitation was published in August, 1967. It concluded that for every \$1 of State-Federal tax money that is invested in a successful rehabilitation client over a working lifetime, that the individual increases his earnings by \$35 for every \$1 of rehabilitation funds invested in him.

This federal report mentioned above gives 35:1 odds in favor of the client and 5:1 in favor of one investor. Therefore, it would seem to make a great deal of sense for the legislators who make decisions about the rehabilitation programs of this state to support the agency's request for state money to the maximum.

Many private citizens and professional people who are interested in rehabilitation in Nebraska have repeatedly asked why the general agency, i.e. The Division of Rehabilitation Services, is not funded more adequately.

Dr. Floyd Miller, the Commissioner of the Department of Education, recently in a meeting of professional people interested in the manpower problems of this state, stated: "Rehabilitation of all the programs of state government should be the easiest to sell to the budget committee." Another man whose word is well respected in this state was recently heard making the statement that rehabilitation is one service that the state can't afford to wait in funding properly because any delay costs more money and magnifies the problems with which the handicapped person is confronted.

The federal rehabilitation office maintains a regional office in Kansas City, Missouri. Mr. Harry E. McGuire, an assistant regional representative of the regional office, was asked by the project director to prepare a report providing information for the last ten year period of how much federal Section 2 money has been available to the State of

Nebraska for its rehabilitation programs and how much state funds would have been required to match this money in full.

This report was secured and the rehabilitation record was carefully studied to determine the amount of state funds that were allocated each year and how much federal money was not claimed. Table 4, page 67, was developed with this information and shows that in a seven year period, six and one-half million dollars went unclaimed.

If this money could have been used for its designed purpose, which is to help pay for the cost of rehabilitation of the handicapped in the state; the result could have been tremendous.

Over an 8 year period, the mean cost experience per rehabilitation case of the general agency has been \$1,035. The majority of the people that have received rehabilitation services have been caught in the dependency cycle before but usually not after rehabilitation. If only the federal share of Section 2 money that went unclaimed could have been used in this state there is a good possibility that 6,280 additional handicapped Nebraskans could have been rehabilitated. This doesn't consider the state matching money that could have accomplished the same task in helping more people.

CASELOAD STATISTICS - STATE AND REGION

It was decided to review the 1967 production figures relative to the seven states area that form Region VI, as recorded in "The Caseload Statistics State Vocational Rehabilitation Agencies, Fiscal Year 1967." This comparison reflects the production in states very near or contiguous to Nebraska and infers that because of this proximity, many of the problems or advances made in rehabilitation would be similar in nature. However, when comparisons are made between states, a common reference point would be to utilize the population of each of the states. The following figures in Table I give the 1966 population for the states in Region VI as estimated in the "United States Facts, Statistics and Information" prepared by the Bureau of Census, U. S. Department of Commerce

TABLE I

Persons Rehabilitated and Served According to Population

<u>State</u>	<u>Population</u>	<u>Rehabilitated</u>	<u>Served</u>
Missouri	4,508,000	4,439	11,112
Minnesota	3,576,000	2,413	9,189
Iowa	2,747,000	2,298	9,121
Kansas	2,250,000	1,212	3,631
Nebraska	1,456,000	1,160	4,589
South Dakota	682,000	485	1,836
North Dakota	650,000	393	1,867

Following the population figures, the numbers of persons rehabilitated and cases served per state are given. These are the combined figures as reported by the blind and general rehabilitation service for 1967. It will be noted above that Nebraska is 5th in population and production as compared to the other seven states in the region.

TABLE II

Persons Rehabilitated and Served Per 100,000 Population

	<u>Rehabilitated</u>	<u>Rank</u>	<u>Served</u>	<u>Rank</u>
U. S. Total	87		287	
Region	78		261	
Missouri	98	21	246	35
Iowa	84	26	332	23
Nebraska	80	30	315	25
South Dakota	71	31	269	30
Minnesota	67	34	257	33
North Dakota	60	36	287	29
Kansas	54	45	161	51

A more meaningful indices of how well a program is functioning within a population is to convert the number obtained within the various categories to the rate per one hundred thousand population served and to rank the production according to these rates. Table II, above, gives a region breakdown of numbers of persons rehabilitated per 100,000 for the fiscal year ending June 30, 1967.

Although Nebraska, according to the population figures shown above in Table I, is fifth in the region in population and in numbers rehabilitated, the altered perspective shown in Table II changes Nebraska's ranking to third in the region and 30th in the United States. This table also shows Nebraska now to be second in the region in people served and 25th in the nation in this characteristic.

Another set of statistics that can be very meaningful to identify trends that are taking place in a state or within a region are the age groups that are currently being served. These figures may be indicative of the type of cases selected for rehabilitation, and there is a distinct possibility an agency can develop blind spots as to whom they are really serving. Therefore, an evaluation of the program of the agency should be done annually, utilizing the "Caseload Statistics" mentioned previously, as well as the "Characteristics and Trends of Clients Rehabilitated" upon publication, to provide an objective means of self critique. Of all of the cases that were closed and rehabilitated within the fiscal year ending 1967 in Region VI, 31.9% of Nebraska's 1,160 cases were age twenty years or less; during the same period it closed 20.3% in which the people were age forty-five and over. The regional figures are as follows:

TABLE III

<u>Percentage Rehabilitated According to</u>	<u>Selected Age Groups</u>		
	<u>% Less than 20</u>	<u>% 45 and Over</u>	<u>Median Age</u>
U. S. Total	22.8	27.2	33
Kansas	27.8	21.3	30
Minnesota	30.3	21.4	29
Nebraska	31.9	20.3	29
South Dakota	34.0	16.3	26
Missouri	34.1	21.3	28
Iowa	35.9	19.3	27
North Dakota	37.2	14.5	25

In the younger age group there were four other states in the region that served a larger percentage of people than Nebraska. In the group of older age population Nebraska was at the median of the region, with three states

serving more, and three states serving fewer. The actual median age client served by Nebraska during 1967 was age twenty-nine, as compared to the national median of thirty-three. It is felt that more should be said about the age group that Nebraska has served in the past year. A comparison of Nebraska's production with the region appears very favorable, and the Directors of the agencies and their staff could feel that they are doing a very exceptional job, particularly since the other states within the region seem to be serving essentially the same type of population. However, the National Total reflects that 22.8% of the population rehabilitated were less than 20 and 27.2% were 45 and over. The implication of these figures are that throughout this region there is a very good possibility of a selectivity factor operating in that the younger and possibly more easily rehabilitated cases are being selected for service rather than the older person with less potential for rehabilitation. This state program should look at itself and investigate the possibility whether or not that the people it is serving represents a good balance in its age breakdown. It should then alert its counselors of the problem and try to regain the balance of the people necessary for good representative rehabilitation. Another danger is the possibility of the state becoming complacent with its production efforts and decide that if the rest of the region is serving this population, that this is the population that they will continue to serve as well.

Another area that merits close scrutiny is the educational level that has been achieved by the people that had been rehabilitated by the state agency during 1967. Of the cases closed by Nebraska as rehabilitated, 16.5% had completed eight grades or less at the time the case was accepted for services. The chart below shows that Nebraska served fewer cases in this educational range than any other state within the region. These cases

TABLE IV

Percentage of Persons Rehabilitated with 8th Grade Education or Less

<u>Cases Closed</u>	<u>Rehabilitated</u>
U. S. Total	32.9
Missouri	28.8
Kansas	22.6
South Dakota	21.1
Iowa	18.9
Minnesota	18.4
North Dakota	18.1
Nebraska	16.5

undoubtedly are more difficult to rehabilitate than those persons with a higher level of education. One would expect that persons who complete a higher level education would be more strongly motivated, possibly more intelligent and have a home environment much more conducive to successful completion of a rehabilitation program. Again it will be noted that U. S. total percentage rehabilitated is considerably higher than the majority of the region and twice that of Nebraska. This is the group that the state agency should be giving more attention to, since they represent a much more complicated and severely involved type of case.

The next chart shows a regional and state breakdown of the cases closed in 1967 and the highest grade the client had completed at the time of acceptance.

TABLE V

Percentage of Persons Rehabilitated with 12th Grade Education or More

	<u>Percentage</u>
U. S. Total	40.9
Missouri	48.6
Iowa	53.4
Kansas	54.3
Nebraska	56.5
Minnesota	57.7
South Dakota	63.8
North Dakota	69.0

Nebraska's percentage of 56.5 placed them in the middle with three states being above and three states being below. These figures may indicate greater selectivity toward the more highly educated group. The region again, shows up in very poor contrast with the U. S. Total.

TABLE VI

Primary Source Support of Clients at Time of Acceptance

	<u>% Current Earning</u>	<u>% Family or Friends</u>	<u>% Public Institutions</u>
U. S. Total	20.7	51.4	6.1
Nebraska	14.0	52.7	12.8
Minnesota	14.3	49.0	3.4
North Dakota	17.0	57.3	4.1
Iowa	18.2	57.6	4.1
Kansas	20.1	52.9	3.5
Missouri	20.2	55.1	4.1
South Dakota	21.1	56.5	10.6

Table VI above, shows the regional figures for 1967 as to the primary source of support to the clients that were served at the time the cases were referred to rehabilitation services. The most significant observation to be drawn from this set of figures is that Nebraska with its record of 12.8% of cases being supported by public institutions at time of referral and fewer wage earners was serving a population that is definitely in need of rehabilitative services, and should be recognized for their efforts in this area.

TABLE VII

Percentage Receiving Public Assistance at Acceptance and Closure

	<u>% At Acceptance</u>	<u>% At Closure</u>
U. S. Total	12.4	5.8
Missouri	16.4	11.0
Kansas	12.5	4.2
Minnesota	12.4	5.7
Nebraska	12.1	5.9
Iowa	11.7	5.6
North Dakota	9.2	2.5
South Dakota	8.2	6.0

Nebraska's at the median, regionally as well as nationally.

TABLE VIII

Mean Weekly Earnings

	<u>At Acceptance</u>	<u>At Closure</u>
U. S. Total	\$ 9.18	\$51.31
Nebraska	7.34	55.15
North Dakota	8.58	69.12
Minnesota	9.10	63.61
South Dakota	9.88	62.05
Iowa	10.49	62.99
Missouri	10.90	47.23
Kansas	14.35	61.36

The above figures show that Nebraska was serving a population that definitely was in need of rehabilitation services at time of acceptance. The lowest mean weekly earnings at acceptance was Nebraska with \$7.34 and the highest was Kansas at \$14.35.

The following chart is the breakdown of the average cost of rehabilitation. In the average cost of purchased services Nebraska's figure was comparable to four other states with two states being considerably higher in their average cost for rehabilitating a client. The two states where the closure figure was almost twice as much as Nebraska's had the smallest population within the region. It is possible that their diagnostic, training and maintenance costs are factors that would reflect disproportionately higher cost figures.

TABLE IX

Average Cost of Purchased Services

	<u>Average Cost per Client</u>
U. S. Total	\$505
South Dakota	951
North Dakota	832
Minnesota	558
Iowa	473
Kansas	426
Nebraska	424
Missouri	416

In the publication called "Characteristics and Trends of Clients Rehabilitated in Fiscal Year 1963 - 1967", it was noted that the average length of time from referral to acceptance was two months, and the average length of time from acceptance to closure was ten months. The following chart gives information in these categories and although Nebraska had 32.6% of its cases in a referred status for more than three months, it was almost the lowest in the region in this category.

TABLE X

Time to Rehabilitate a Client

	<u>% in Referred more than 3 mo's</u>	<u>Median Months from Acceptance-Closure</u>	<u>Rank</u>
U. S. Total	26.1	10	
Kansas	26.4	11	3
Nebraska	32.6	11	3
Missouri	34.3	8	1
South Dakota	42.1	16	6
North Dakota	44.0	19	7
Minnesota	45.9	14	5
Iowa	47.6	11	3

Nebraska's figures on the length of time that it takes to rehabilitate a person from acceptance to closure was eleven months which compares favorably with national statistics.

Another area to look at and which can give very important information is how a state supports its rehabilitation programs. The following chart shows per capita expenditures per 100,000 population. The states are ranked in the order of highest total 1967 state and federal expenditures to the lowest in Table XI. Nebraska ranks 39th in the nation as far as being funded for

TABLE XI

	<u>1967 Per Capita Expenditures</u>	<u>Per 100,000</u>		
	<u>Total State and Federal Funds</u>	<u>State Funds</u>	<u>Regional Rank</u>	<u>National Rank</u>
U. S. Total	\$ 1.51	.39		
South Dakota	1.80	.45	1	22
Iowa	1.66	.42	2	26
North Dakota	1.42	.35	3.5	32
Minnesota	1.39	.35	3.5	36
Nebraska	1.28	.32	5.5	39
Missouri	1.27	.32	5.5	40
Kansas	.78	.19	7	52

its rehabilitation program. Within the region four other states are funded in a larger amount than Nebraska. Nebraska spends thirty-two cents per capita of its state funds on rehabilitation and when matched by Federal funds this gives Nebraska a total of state and federal funds of \$1.28 per capita. Within the region four other states are better funded.

The attached Table XII indicates the budget estimates for the State Rehabilitation Agency in Nebraska for the fiscal years 1968-1969. This gives information on how the state programs are being funded and supported by the state. An area of importance to the future of the program in Nebraska is Item 3 where it is shown the Federal allotment that possibly will not be used in the state during the years 1968-1969. For the past ten years Nebraska has not been able to match all the federal money that was allocated and as a result has lost the advantage of having several million dollars that could have been invested in Nebraska's program.

Rehabilitation is a program which is known nationwide for the quality type of work that it does, and for its careful usage of State-Federal funds. Recent studies have indicated that for every Federal tax dollar that is invested in a rehabilitation client, the client experiences a lifetime increase

in earnings and the value of the work activity is estimated to be \$35 for every dollar expenditure made in his behalf.

The biennial report for 1966-1967 published by the Division of Rehabilitation of Nebraska Department of Education shows that a rehabilitated client's earnings were increased on an average of \$218.00 per month, and that 144 disabled people are removed from welfare roles with a savings to public assistance by \$214,620 per year.

There is much tangible evidence of the saving of tax dollars through judicious spending or, better still, investment in the greatest latent asset that we possess: the handicapped population. The freeing of this group from the bonds of handicapping disability to become productive has not only added millions of dollars in tax revenues yearly, but has also relieved the state of the responsibility of their support.

If the people of Nebraska and their representatives in the State Legislature will understand that rehabilitation is a very worthwhile program, and that this is one program where state and federal tax money is used the wisest, then they will give the program the full support that it deserves.

This year, with Congress and the Senate and Federal Budget Committee making cut-backs, it was reported to the office of Statewide Planning that rehabilitation services was one agency which would not be cut back as severely as many of the other programs. The question has been asked, "Why is this so?" The answer has been given that Congress has believed in the rehabilitation programs across the United States for quite a number of years and has regularly supported them. It has been indicated that Congress feels that rehabilitation is one of the programs in the United States that, through its established professional agencies and staff, and through its rehabilitation processes, has the capability of serving a section of the United States society that is in need of services. Rehabilitation and other programs have stated for years that it is good business to hire the handicapped; which, by comparison, should be a mandate to the state legislature to fund the rehabilitation programs properly so that they can provide the services as needed throughout the state.

NEBRASKA PENAL REHABILITATION

Based on new Federal legislation the State Rehabilitation agencies can now provide services to the public offender. However, the applicant must meet the eligibility standards established by the State agency. The personnel of the project office felt it was important to know what had been accomplished by the Nebraska Agencies in the field of penal rehabilitation.

It was found that there had been several attempts by the Division of Rehabilitation Services to become involved in this field. One program had been established at the Kearney Boys Training Center, with funds provided through a third party agreement between Rehabilitation and the Department of Public Institutions. However, it appeared that more could be achieved for this group of handicapped persons. A meeting was scheduled by the project staff with key officials of the State of Nebraska. It was hoped that a good discussion and review of basic problems would insure the establishment of solid communications at all levels and set the stage for cooperative efforts in the future. In preparation for this meeting, reports were obtained from the Oklahoma Rehabilitation program describing its work in the penal field. Copies were sent to the people that had been invited to the meeting. Mr. Voyle Scurlock, the consultant to the Project Office, was invited to attend the meeting so that the group could benefit from his experiences in the general field of rehabilitation, as well as the penal field.

It was determined that the operation of the penal program, under Mr. Sigler's* guidance was providing an excellent program of preparing

*Mr. Maurice H. Sigler, Deputy Director, Division For Correctional Servi

the prisoners for their return to society. It was apparent they felt they were doing a good job. However, Mr. Sigler indicated his willingness to have the State rehabilitation representatives take a good look at all his programs and see where their service could be fitted in on a supplementary basis, but providing a necessary and supporting service. The careful designing of new programs in Nebraska should have a beneficial and a lasting positive effect on the public offender that will be served by the various programs. It should be added that this type of an effort certainly will provide for a better society in which to live. The Project Director initiated a meeting which was attended by the following people:

Jack Hobbs, Project Director
Statewide Planning for Vocational
Rehabilitation Services

Garry D. Cartwright
Administrative Assistant
Division of Rehabilitation Services

Fred A. Novak, Director
State Division of Rehabilitation
Services - Lincoln, Nebraska

Donald Duncan, Director
Department of Public Institutions

Charles L. Wolff, Jr., Superintendent
Nebraska Prison Industries

Maurice H. Sigler, Warden
Kearney Boys Training Center

Ed. L. Scarborough, Associate Warden
Penal Complex

John S. McCarty, Superintendent
Kearney Boys Training School

Voyle Scurlock, Consultant to Project
Office, Oklahoma City, Oklahoma

Ronald B. Jones
Associate Warden-Treatment
Kearney Boys Training School

Calista Cooper Hughes, State Senator
First District

Clayton Yeutter
Executive Assistant to Governor

Samuel J. Cornelius, Director
Technical Assistance

The meeting gave the participants an opportunity to take a preliminary look at their problems in the public offender field. They tentatively planned a program to be designed at one institution to

demonstrate what can be accomplished between the Division of Rehabilitation Services and the Department of Institutions penal programs in a team effort.

Another direct result of this meeting was that the key members of the group decided that they should visit the State of Oklahoma, and look at the penal programs that are operating successfully in that state.

Since the above meeting and the visit to Oklahoma, the Division of Rehabilitation Services, under its third party program, has established a vocational rehabilitation unit at the Nebraska Boys Training School in Kearney, Nebraska, and another at the Penal Complex in Lincoln, Nebraska.

DIVISION OF REHABILITATION SERVICES
THIRD PARTY FUNDING AGREEMENTS

Some leaders of this State have advised that the average legislator is not interested in how much federal money has been lost or unclaimed by a state agency and have suggested that this part of the report be de-emphasized. It is true that since the money was not fully matched by state money, that it is ancient history but at the same time, statistics of this type provide an opportunity to observe the growth pattern that the Division of Rehabilitation Services has made in almost a decade, the number of people that it has served in this time and how well the legislature has funded its program. This concern of the large amount of federal money consistently being lost to the Division of Rehabilitation Services has been expressed by large numbers of Nebraska citizens who are both knowledgeable and interested in rehabilitation in this State.

Table 1, page 65, shows that a greater percentage of handicapped people are being served each year in this State and that the programs are being better funded and provided with more staff. One of the charges of the project guidelines was that the growth of rehabilitation services in any state should be an orderly growth. A review of the type of people that the programs are serving and their record of success can be very meaningful in reflecting the growth pattern of a program. Mr. Scurlock, in his report, felt that the increased use by the Division of Rehabilitation Services of third party agreements provided a method of serving more handicapped people in the State but he also felt that the increased use of this technique was directly traceable to inadequate appropriations to the general agency. He pointed out that one of the dangers that the general agency might encounter if it continued to use the third party funding agreement method so intensively was that it could result in an unbalanced program in this State.

Table 9, page 75, has been developed by the project office to provide a summary of the third party agreements involving the general agency. Third party funding has been used in many states by the rehabilitation agencies in order to gain more money to rehabilitate the handicapped living in those states. An example of the establishment of third party funding is that when two governmental programs, state, county, or local, recognize a rehabilitation need that is not being met in their existing programs of service, they carefully plan a program that is designed to serve handicapped individuals. If the two programs that are entering a cooperative agreement are state programs, the funding of the program can be accomplished easily and without any additional cost to the state which is one of the unusual but very attractive features of third party funding. The Federal Office of Rehabilitation allows the state agency to accept in its contractual agreement either direct appropriations from the other state agency or gives them monetary credit for in kind services. The staff members who will be working for instance in a vocational rehabilitation unit and whose salaries are being paid by the hospital can be transferred to the rehabilitation unit. Their salaries can be matched or can be used for in-kind matching money on a three to one basis. Other in-kind money or in-kind services can be

used for matching purposes as well. This technique allows the state to gain a great deal more with its state appropriations without costing any more state tax money.

Table 9, page 75, shows that the Division of Rehabilitation Services has nine(9) third party agreements with the Department of Public Institutions with an estimated annual expenditure of \$1,063,990. They have qualified for state money by listing in-kind services in the amount of \$356,248 which was matched by federal money in the amount of \$702,742. This has resulted in a sizeable number of people, both professional and clerical, who now work in new rehabilitation programs within the various institutions and with additional numbers of handicapped individuals being served.

A report was recently provided by Mr. Dale Hatch, the State Supervisor, Mental Handicap Services of the Division of Rehabilitation Services. It shows that during fiscal 1968 under the third party program there were 935 handicapped persons that had been served, with 227 of these people being closed rehabilitated. A report prepared by Mr. Lloyd Lowery, Supervisor of the Vocational Rehabilitation unit at the Hastings State Hospital, gives some very interesting statistics concerning the successful operation of the Hastings unit. Mr. Lowery reports that the unit at the Hospital has been in operation for approximately two(2) years. During the first year of operation, or the period from June 30, 1966 to June 30, 1967, he reported that there were 98 patients referred to the unit from the three treatment units of the Hospital. Of the 98, a total of 60 were accepted for services. During this first year of operation, the staff of the unit closed 42 cases as being successfully rehabilitated. Mr. Lowery pointed out though that the 42 that were closed were not necessarily a part of the 60 that had been originally accepted for service. During the second fiscal year of operation 93 referrals had been made to the unit of which 75 had been accepted. During this second year 70 cases have been closed rehabilitated. During this two year period 22 cases had to be eliminated from the program for various reasons. The Hastings Vocational Rehabilitation Unit offers various types of training within its facility. For example, janitorial training, clerical training, bookkeeping, etc. In the last two years of operation 68 patients have completed a training program and are now gainfully employed outside the Hospital. Mr. Lowery has pointed out that the hospitalization for these 68 individuals prior to the referral to Vocational Rehabilitation was approximately \$275,000, averaging out to about \$14,300 per patient. The Division of Rehabilitation Services has spent an average of \$120 per individual or a total of \$8,200 of case service funds. It should be noted that these service funds are expenditures made for the clients' rehabilitation and are usually a cost that is not sustained within the unit. A good example would be the cost of maintaining the person outside the Hospital in terms of maintenance or provision of other services. This report of Mr. Lowery's is extremely important since it points out that the 68 clients with which they were successful had spent an average of 28 months in the hospital prior to being served by the Vocational Rehabilitation Unit. It took 9 months on an average for these patients to be made ready for employment. Today these 68 people are living outside the hospital and are working. Their average income is \$2,000, but from

their earnings they are paying federal and state taxes as well as payments into the social security fund. The point that is being made is that it costs considerably less to rehabilitate these patients when they are ready than it does to maintain them in the hospital.

Many of these third party agreements are relatively new and will take time to mature before they start producing good solid numbers of persons served and rehabilitated, but if people will be patient and give each of the units a chance to function properly, the results should be very worthwhile.

One observation about the third party funding agreement is that a very large percentage are designed for psychiatric programs. It is certainly not the intent of the writer of this report to suggest that the agency cancel any of its cooperative agreements at this time but that they should give strong consideration in the development of future cooperative third party agreements to bring in other programs which would possibly balance out the disability groups being served. Other programs the Division of Rehabilitation Services might consider investigating for third party funding would be the School for the Deaf in Omaha, the educational service units, and other public school systems across the State, as well as the various welfare offices throughout the State.

The Division of Rehabilitation Services has a third party agreement with the Nebraska Workmen's Compensation Court. This allows a vocational specialist to be assigned full time to work in the Nebraska Workmen's Compensation Court with the purpose of reviewing claims that have been filed and making referrals to the appropriate rehabilitation agency. Three schools have entered into third party agreements with the general agency. Table 9, page 75, shows that the estimated state and federal expenditures for the operation of these 13 programs will be \$1,298,480. This should result in the establishment of good working relationships between the various programs and the Division of Rehabilitation Services. Sizeable numbers of handicapped people will be served through these programs with a large percentage of handicapped people being successfully rehabilitated. However, in a critique of the growth of third party funding in Nebraska, consideration should be given by the Director of the Division of Rehabilitation Services, by the Budget Committee, and the agencies involved, of some of the complications that can result from this funding technique.

It is recommended that the Division of Rehabilitation Services, in the establishment of new third party agreements, include as many other disability groups as possible to correct a possible imbalance of services to any one disability group.

It is recommended that the Division of Rehabilitation Services plan carefully and limit the number of third party agreements that they will enter into in any designated period of time.

It is recommended that the Division of Rehabilitation Services review its supervisory practices that it is currently providing in all of its third party agreements.

FISCAL RESPONSIBILITY

A few months ago the Division of Rehabilitation Services discovered that it had overspent its case service funds in the amount of \$98,000.00. When the situation was evaluated, it was found that the agency had overspent a percentage of federal money available to it. This forced the agency to place a moratorium on any spending until it determined the magnitude of the problem. It was then that the amount of \$98,000.00 overspending was identified. A properly paid accountant employed on the staff of the agency could have helped to prevent such a situation from occurring.

The regional office of the Rehabilitation Services Administration helped the Division of Rehabilitation Services to identify expenditures that could be legitimately claimed and the writer of this report understands that the deficit has been reduced to approximately \$13,000.00. It is possible that the agency can absorb the remaining deficit. The situation that remains unchanged is that during the period August 9, 1968 through June 30, 1969, the Division of Rehabilitation Services of Nebraska will not have Section II money, i.e., basic support money to spend in serving any disabled Nebraskan who applies for services as a new applicant. This represents a period of eleven months where large numbers of handicapped Nebraskans will not receive the services of an agency whose only existence is to serve the handicapped of this state. Fortunately, through its third party programs the agency will be able to continue to service certain segments of the disabled population.

The agency underestimated the numbers that they would be serving during this current biennium. However, they are not totally to blame. The budget committee has for years granted only a partial amount that the agency has requested for its operation. The following article appeared in the September 1968 issue of the Rehabilitation Association of Nebraska Newsletter. It expressed the concern and feelings of a majority of those associated with this organization.

MONEY FREEZE

"As the editor of the RAN Newsletter, I will attempt to project the feelings of the RAN organization; however, these may not necessarily be the views of all members of RAN. If memory serves this writer correctly, the freeze that the Vocational Rehabilitation Services agency imposed upon their rehabilitation counselors came as of August 9. At that time, a news release indicated that it would take approximately two weeks to analyze the situation, and they would then be in a position to predict the types of services that would be available for the remainder of the year. In a statement released approximately two weeks later, it was indicated that Vocational Rehabilitation would need an additional \$98,000.00 in order to be eligible for the federal

funds necessary to operate the Rehabilitation Program. The membership of RAN consists not only of Vocational Rehabilitation counselors, but also of welfare directors and workers as well as other interested people in the field of rehabilitation. This Newsletter is also made available to each member of the state legislative body. One group which is not included in the mailing list of the RAN Newsletter is that group which is served by the members of RAN, that is the handicapped of Nebraska. It would be this writer's opinion that the handicapped in the state of Nebraska should have a voice in what is being done for them through out the state.

The facilities connected with Rehabilitation Services are many and varied as far as services provided. It would be difficult to list the number of facilities involved in the program for the handicapped, and it would be even more difficult to ascertain the many problems which have arisen due to the freeze imposed by the Division of Rehabilitation Services. This freeze not only affects private facilities but it also affects state operated trade schools as well as universities and colleges that educate many of the handicapped in Nebraska.

It is a sad commentary in the state of Nebraska when all of our political leaders are talking of the greatest state in the nation as well as the land of opportunity for all people. Nebraska has been noted as being the land of plenty; however, for many years the handicapped person in Nebraska has taken a back seat as far as financial appropriations are concerned. This editor feels that all members of the Unicameral should contact the various facilities and agencies, universities, etc. dealing with the handicapped of Nebraska to determine exactly what the plight of Rehabilitation has been for so many years here in the state of Nebraska. Many comments received by your editor are as follows: This is not the first time Vocational Rehabilitation has been without funds nor will it be the last. You can not depend upon Vocational Rehabilitation because as soon as you begin to work with them and understand the operation, they change counselors. The shortage of counselors makes adequate decisions and adequate planning for the handicapped impossible because each rehabilitation counselor currently working in the state of Nebraska is extremely overburdened. These kinds of comments can no longer be tolerated if the state of Nebraska Division of Rehabilitation is to serve the needs of the handicapped throughout this state. This editor pleads, not only with the governmental officials involved, but with the senators and the interested citizens of this state to put forth whatever efforts are necessary to bring about the additional funds necessary to adequately run a rehabilitation program in the state of Nebraska which would be second only to its noted football team."

The fiscal predicament that the agency is currently facing is not peculiar to Nebraska. Several of the surrounding states are in exactly the same situation. The Division of Rehabilitation Services had been constructively advised by the project office of the comments that have been made by the budget committee of the state as to its major weaknesses in budget preparation and presentation.

Basic issues that are important to the continuation of rehabilitation in this state are as follows:

FUNDING ABILITY:

Over the past several years the Division of Rehabilitation Services has experienced considerable difficulty in obtaining desirable amounts of state funds to operate its program. In the chapter on third party funding, it was noted that this agency in order to expand its program has entered many third party agreements with other governmental units in order to serve the handicapped as needed; otherwise, the progress of the program would have been very marginal. Rehabilitation should be one of the easiest programs for which to request and justify funds. Comments have been made that as long as rehabilitation functions in state government where it is today it will continue to experience funding problems. The total budget for the operation of the Division of Rehabilitation Services represents only 1.4 percent of the total budget of its parent agency. This condition makes it very difficult for the needs of the rehabilitation agency to be identified by the public as well as by key governmental officials. They tend to become submerged, especially when the agency has seemingly lacked the strength to be heard. The Department of Education has had to make decisions concerning specific directives of the State Budget Committee in matters of salary increases and numbers of personnel to be added or deleted from its staff.

Legitimately these decisions are within the prerogative of the Department to make since these are administrative by nature. However, during the past biennium the budget bill for the State of Nebraska listed a maximum amount that could be spent by the Department of Education for personal services, i.e., staff and salaries. Thus in legislative language, the Department of Education found that a definite personal services limitation had been placed on them. It is interesting to note that no other unit of state government was listed in this limitation. Many people of Nebraska who are interested in a good sound rehabilitation program feel that as long as rehabilitation is a part of the Department of Education that it will never grow as a rehabilitation entity.

The salary schedule of the Division of Rehabilitation Services has always been lower than that of any division of the Department of Education. As of July 1, 1968, the Division of Rehabilitation Services ranked nationally in position 42 in the category of salaries paid to its counseling staff. Only 11 other states or territories were paid less. Low salaries paid by the Division of Rehabilitation Services and other problems have caused many skilled rehabilitation persons to leave the rehabilitation agency for other employment. The image of an agency tends to dissipate under these conditions.

The Commissioner of Education recently gave permission for the Division of Rehabilitation Services to include in its proposed budget for the next biennium the increasing of the salary schedules for the

agency up to the level paid to all the other divisions of the Department. Although the Department of Education bases its salary schedule on the minimum requirement of a master's degree, many of the professional staff of the general agency have attained this degree (See chart on page 137). It is felt strongly that this corrective step should have been accomplished years ago!

Following is a listing of the salary ranges recorded in the July 1, 1968 booklet entitled "State Salary Ranges" published by the Department of Health, Education and Welfare, Office of State Merit Systems. This listing included only the salary ranges paid in Region VI, but in parenthesis is listed the rank position of each of the states compared to the top salaries being paid in the United States today.

Missouri	8,400-11,000	(3)
South Dakota	8,100-10,332	(10)
Minnesota	7,392- 9,744	(15)
Iowa	7,000- 9,520	(19)
North Dakota	6,000- 9,300	(27)
Nebraska	6,600- 8,500	(42)
Kansas	6,360- 8,160	(45)

This report indicated the mean minimum salary paid to rehabilitation counselors in the United States is \$7,180 while the mean maximum salary is \$10,913.

Other states have been making sure that their salary schedules remain competitive so they can attract the best trained rehabilitation counselors available. This is a very pragmatic approach since a good rehabilitation counselor can save the state many times the cost of his salary each year plus helping the disabled and handicapped to return to employment. Let it be noted again that studies have indicated that the handicapped person experiences an increase in earnings of \$35 for every \$1 invested if he is successfully rehabilitated.

In the past six months the following changes have occurred in the salary schedule paid by the states in Region VI:

Missouri has increased its top salary paid to counselors by \$500.

South Dakota has increased its schedule by \$924.

Minnesota -- No Change

Iowa has reduced its maximum by \$1,000.

North Dakota has increased its schedule by \$700.

Nebraska -- No Change

Kansas has increased its schedule by \$396.

TABLE

Salary Ranges - Rehabilitation Counselors
(July 1, 1968)

<u>State or Territory</u>	<u>Amount</u>	<u>State or Territory</u>	<u>Amount</u>
*New York	9,710 - 11,740 (a)	*Colorado	7,176 - 9,168 (a)
*California	9,396 - 11,400	Virginia	7,032 - 9,168
*Missouri	8,400 - 11,000 (e)	*District of Col.	6,981 - 9,078
*Wyoming	8,460 - 10,980 (a,c)	*Tennessee	7,080 - 9,060
Alaska	9,108 - 10,932	Pennsylvania	7,055 - 9,011
*Idaho	8,700 - 10,800	Indiana	7,200 - 9,000
*Wisconsin	8,136 - 10,584	*Oregon	7,200 - 8,940
Texas	8,628 - 10,512	*New Jersey	7,218 (f)
*Georgia	7,752 - 10,380	Montana	6,840 - 8,940
*So. Dakota	8,100 - 10,332 (a)	Alabama	6,948 - 8,928
Connecticut	7,940 - 9,920	*Florida	6,420 - 8,760
*West Virginia	7,620 - 9,900	Mississippi	7,750 - 8,750
Washington	7,752 - 9,776	Massachusetts	6,895 - 8,674
*Ohio	7,176 - 9,776	No. Carolina	6,708 - 8,520
*Minnesota	7,392 - 9,744	Nebraska	6,600 - 8,500
*So. Carolina	7,135 - 9,655	*New Hampshire	6,600 - 8,300 (a)
Utah	6,840 - 9,564 (a)	*Oklahoma	6,240 - 8,220 (a)
Nevada	7,850 - 9,533	*Kansas	6,360 - 8,160 (a)
*Iowa	7,000 - 9,520 (a)	Hawaii	6,048 - 7,716 (a)
Arizona	6,500 - 9,500	Louisiana	6,500 - 7,700
Vermont	6,968 - 9,464	Maine	6,240 - 7,592 (a)
Delaware	7,008 - 9,444	Arkansas	6,600 - 7,500
*Michigan	7,663 - 9,438 (a)	Kentucky	5,760 - 7,344 (a)
New Mexico	6,900 - 9,420 (a)	Rhode Island	6,032 - 7,332 (a)
Maryland	7,170 - 9,417	Virgin Islands	5,940 - 6,984 (a)
*Illinois	7,548 - 9,384	Puerto Rico	4,440 - 5,400 (a)
*No. Dakota	6,000 - 9,300 (a)		

(a) Longevity payments are added to this base pay range.

(c) Minimum qualifications in this State significantly higher.

(e) This range includes the lowest minimum and highest maximum limits used by jurisdictions for this class.

(f) After a short period (6 months - 1 year) of satisfactory service in this class, the employee is automatically promoted to the next level class which is at a higher pay scale.

*Salary range revised since last semi-annual survey.

TO WHOM IT MAY CONCERN: ERRATA

PLEASE ATTACH THIS CORRECTING INFORMATION, CONSISTING OF COPY OF LETTER FROM DR. PAUL F. JOHNSTON, STATE SUPERINTENDENT OF PUBLIC INSTRUCTION, STATE OF IOWA, AND ATTACHED PAGE OF QUOTE FROM HARBRIDGE HOUSE REPORT TO FINAL REPORT OF NEBRASKA COMPREHENSIVE STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES. THANK YOU.

Marion E. Clark, Director
Services for the Visually Impaired
State of Nebraska
State Capitol
Lincoln, Nebraska

COPY

May 13, 1969

The Honorable Norbert T. Tiemann
Governor of Nebraska
State Capitol Building
Lincoln, Nebraska 68509

Dear Governor Tiemann:

An official publication of the State of Nebraska carries a misstatement pertaining to a matter of program governance in Iowa that we wish to call to your attention.

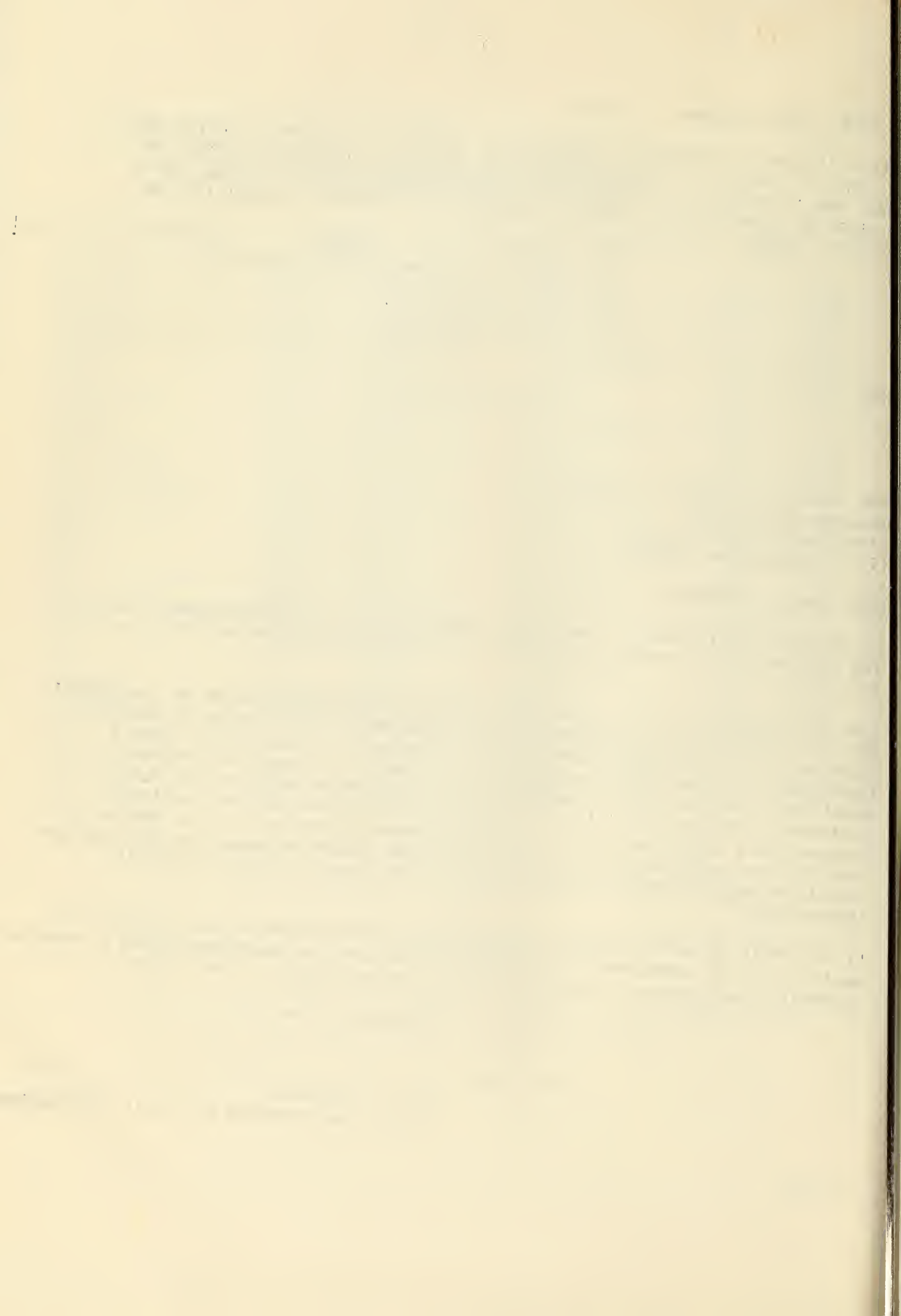
The final report of the Nebraska Comprehensive Statewide Planning for Vocational Rehabilitation Services released by you on January 7, 1969 states on page 64 that the "Iowa (vocational rehabilitation program) has been placed under a Department of Social and Rehabilitation Services." In Iowa, the program of vocational rehabilitation is administered by the State Department of Public Instruction through its Division of Rehabilitation Education and Services. Attached is a copy of material released by Harbridge House, Inc., of Boston on June 13, 1968 which was a basis for their final report recommending that the Iowa vocational rehabilitation program remain in the State Department of Public Instruction.

If an ERRATA is being prepared in connection with the Nebraska publication, we would like this correction to be listed. Otherwise, we would appreciate a separate correction notice being sent to those who received copies of the report.

Sincerely yours,

Paul F. Johnston
State Superintendent of Public Instruction

PFJ:ga



QUOTE FROM HARBRIDGE HOUSE REPORT

N.B. There may be minor textual amendments during editing but the substantive reasons will be unchanged.

"In our considered opinion the Division of Rehabilitation Education and Services should continue to be part of the Department of Public Instruction. The reasons for this recommendation are several

The Department of Public Instruction has the technical resources necessary for the support of the DRES through a massive expansion of program and it is not obvious that another department would offer superior support.

The Department of Public Instruction has the capability and has expressed the willingness to seek and obtain the requisite funding support.

The similarities between the missions of the DRES and the Department of Public Instruction are no less (and no greater) than the similarities existing between the DRES mission and those of alternative departments in which DRES might be located.

No funding advantage would accrue to DRES from a change in administrative location.

Any change, whether to another department or to independence, would inevitably occasion considerable administrative dislocation at a period when DRES needs to concentrate its energies on the development of the rehabilitation program.

There are no existing state statutory barriers to the service of any group of disabled persons, and therefore none would be removed by a change in administrative location.

The inmates of state institutions (five thousand in number) and those potential cases on the welfare rolls (also about five thousand in number) do not constitute a substantial part, let alone a majority, of those who might become clients of DRES.

The DRES will have, it is proposed, closer relationship with two major educational endeavors: the special education program and the area vocational schools."

POSITION IN STATE GOVERNMENT

The question of where the rehabilitation program belongs in State Government has been pondered from one border of this great country to the other. The Statewide Comprehensive Planning Project for Vocational Rehabilitation of the State of Utah completed a nationwide survey of the placement of the Rehabilitation Agencies in state government. In October, 1967, a report was received from their project office. They reported that of the fifty states that were sent the questionnaire, thirty-eight had responded. Of this number, twenty-seven Divisions of Rehabilitation were under the Department of Education. Nevada was under the Department of Health and Welfare. Six of the states reported having a separate department of rehabilitation within their state and five indicated that the Rehabilitation was under some other form of government.

Since the publication of Utah's study, Kansas and Oklahoma have been placed under the welfare agencies while Iowa has been placed under a Department of Social and Rehabilitation Services. A part of the Federal Health, Education and Welfare Department has reorganized into the Social and Rehabilitation Services with the Rehabilitation portion labelled as the Rehabilitation Services Administration. It is believed that the essential elements that caused this reorganization was the basic concern of how can the public be served more efficiently.

In Nebraska, a Little Hoover Commission Committee was named by Governor Norbert Tiemann. It has recommended the establishment of a Department of Social Services with at least seven(7) basic agencies being Divisions of it. If this becomes a reality and results in a better utilization of state money, a more economical usage of professional personnel, and will help to cut the red tape so that the handicapped, the culturally and economically deprived, and others, can be better served; then, possibly, this is where the Division of Rehabilitation should be located.

Serious consideration should be given to transferring the Division of Vocational Rehabilitation Services as proposed by the Nebraska Analysis Committee, 1968.

Table 1.		General Agency		Fiscal		Case Service		Counseling		Average Cost Per	
		Number of		Total		Expenditure		Man Years		Rehabilitation	
		Cases Accepted		Caseload		Average		Support		Based on Sec. 2	
						Per Counselor		Program		Expenditures	
								(Sec.2)			

Table 3.

NATIONAL MEANS ON REHABILITATION PRODUCTION

NEBRASKA'S PRODUCTION RECORD (BOTH REHABILITATION AGENCIES)

Fiscal Year	Rehabilitations Per Counseling Man-Year (Sec.2)	Average Cost Per Rehabilitation (Sec. 2)	Counseling Man-Years Support Program (Sec. 2)	Total Number Rehabilitated	Average Cost Per Rehabilitation
1968					
1967	37	\$1,750	29.8 + 6.2 = 36.0	1,160	\$1,602
1966	42	1,385	20.8 + 5.1 = 25.9	919	1,086
1965	45	1,143	16.2 + 5.0 = 21.2	806	924
1964	46	1,113	12.5 + 3.8 = 16.3	712	1,020
1963	47	1,027	10.8 + 5.0 = 15.8	595	980
1962	46	990	16.3 + 5.4 = 21.7	691	801
1961	44	953	= 18.7	635	918
1960	47	892			

6,928

Table 4. A REVIEW OF NEBRASKA'S USAGE OF FEDERAL AND STATE BASIC SUPPORT MONEY FOR REHAB. SERVICES*

Fiscal Year	Federal Money Available Under Sect. 2, Basic Support Program**	State Funds Required to Earn Total Amount of Sect. 2, Support Money**	Federal-State Matching Dollar Ratio	Total State-Federal Money Under Sect. 2 Approved & Used by DRS and SVI	State-Federal Expenditures Under Sect. 2 DRS Listed First, SVI Second	Federal Money Lost Due to Lack of State Money Being Made Available
1969	\$3,822,202	\$1,274,067	75:25	\$.....	\$.....	\$.....
1968	3,162,940	1,054,313	75:25	2,586,918
1967	2,731,272	910,424	75:25	1,858,048	1,485,479 372,569	1,492,573
1966	2,376,491	1,090,308	55:45	998,364	804,921 193,443	1,827,391
1965	1,512,627	923,165	79:21	744,687	607,427 137,260	924,325
1964	1,250,555	763,221	60:40	726,354	572,942 153,414	814,743
1963	1,000,146	591,426	59:41	582,955	468,088 114,867	656,203
1962	825,988	487,481	59:41	553,691	441,118 112,573	499,311
1961	747,540	393,923	53:47	583,193		438,448
1960	661,477	351,909	53:47			<u>\$6,652,994</u>

*Figures based on facts from the Vocational Rehabilitation State Agency Program Data published by the United States Department of Health, Education and Welfare.

**State Funds provided by the Regional Representative for Nebraska.

STATE REHABILITATION STATISTICS. TABLE COMBINES THE PRODUCTION
RECORD FOR BOTH THE DIVISION OF REHABILITATION SERVICES AND THE
SERVICES FOR THE VISUALLY IMPAIRED

Fiscal Year	Number of Cases Accepted For Services	Total Caseload Served	Number Rehabilitated	Average Cost* Per Rehabilitation	Number Served Per 100,000 Population	Rank	Numbers Rehabilitated Per 100,000 Population	Rank
1968	2,402	5,595	1,410	\$1,834	**	**	**	**
1967	2,107	4,589	1,160	\$1,602	315	25	80	30
1966	1,514	3,624	919	1,086	245	28	62	30
1965	1,205	3,157	806	924	213	29	54	30
1964	956	2,925	712	1,020	200	28	49	30
1963	910	2,736	595	980	184	28	40	38
1962	857	2,706	691	801	189	25	48	30
1961	971	2,604	635	918	183	25	45	31
Totals	10,923	27,936	6,928	Mean \$1,145 Cost				

*Cost based on total expenditures under Section 2 funding

**These figures are prepared by the Federal Office of Social and Rehabilitation Service, Rehabilitation
Services Administration, and were not available when this Table was prepared.

6 Table 6.

Fiscal Year	General Agency	TOTAL FEDERAL AND STATE EXPENDITURES			COUNSELING		MAN-YEARS		Total Number Rehabilitated	Average Cost Per Rehabilitation Based on Sec. 2 Expenditures
		Support Program (Sec.2)	E & T Program (Sec.3)	Total (Sections 2 & 3)	Support Program (Sec.2)	E & T Program (Sec.3)	Total (Secs. 2 & 3)			
1968		\$2,198,568	\$16,667					1,267	\$1,735	
1967		1,485,479	16,667	\$1,502,146	29.8	-	29.8	1,037	1,432	
1966		804,921	18,772	823,693	20.8	.5	21.3	822	979	
1965		607,427	15,934	623,361	16.2	1.0	17.2	724	839	
1964		572,942	20,215	593,157	12.5	.3	12.8	639	897	
1963		468,088	13,333	481,421	10.8	1.0	11.8	541	865	
1962		441,118	10,133	451,251	16.3	1.0	17.3	634	696	
1961		478,072	10,207	488,279	14.0	.8	14.8	570	839	
S. V. I.										
1968		388,673						143	2,717	
1967		372,569	9,414	381,983	6.2	1.0	7.2	123	3,029	
1966		193,443	9,087	202,530	5.1	-	5.1	97	1,994	
1965		137,260	8,238	145,498	5.0	-	5.0	82	1,674	
1964		154,414	7,073	160,487	3.8	-	3.8	73	2,102	
1963		114,867	6,667	121,534	5.0	1.0	6.0	54	2,127	
1962		112,573	5,096	117,669	5.4	.7	6.1	57	1,975	
1961		105,121	5,105	110,226	4.7	.9	5.6	65	1,617	

S. V. I.

1968		388,673						143	2,717	
1967		372,569	9,414	381,983	6.2	1.0	7.2	123	3,029	
1966		193,443	9,087	202,530	5.1	-	5.1	97	1,994	
1965		137,260	8,238	145,498	5.0	-	5.0	82	1,674	
1964		154,414	7,073	160,487	3.8	-	3.8	73	2,102	
1963		114,867	6,667	121,534	5.0	1.0	6.0	54	2,127	
1962		112,573	5,096	117,669	5.4	.7	6.1	57	1,975	
1961		105,121	5,105	110,226	4.7	.9	5.6	65	1,617	

CASE SERVICE EXPENDITURES BY CATEGORYD.R.S.Amount and Percent Each Is Of Total Case Service Expenditures

Fiscal Year	Total Case Service Expenditures	<u>Diagnostic Procedures</u>		<u>Surgery & Treatment</u>		<u>Prosthetic Appliances</u>		<u>Hospital Convalescent Care</u>		<u>Training and Training Materials</u>	
		Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
1968											
1967	\$844,754	56,897	6.7	23,207	2.8	54,858	6.5	12,764	1.5	332,120	39.3
1966	458,348	30,490	6.7	10,647	2.3	22,584	4.9	7,895	1.7	202,669	44.2
1965	332,838	25,357	7.6	5,891	1.8	20,303	6.1	2,939	.9	158,120	47.5
1964	339,833	48,955	14.4	8,897	2.6	15,326	4.5	5,062	1.5	194,197	57.2
1963	261,673	32,084	12.3	9,261	3.5	19,984	7.6	5,269	2.0	150,430	57.5
1962	262,680	23,035		6,832		13,666		5,537		166,019	

S.V.I.

1968											
1967	181,396	14,472	8.0	17,379	9.6	8,609	4.7	11,534	6.4	54,033	29.8
1966	110,960	6,326	5.7	14,809	13.3	3,941	3.6	7,866	7.1	37,713	34.0
1965	65,490	3,451	5.3	7,057	10.8	2,385	3.6	6,941	10.6	22,613	34.5
1964	80,466	3,960	4.9	6,588	8.2	3,321	4.1	7,532	9.4	27,414	34.1
1963	43,468	3,420	7.9	4,702	10.8	2,285	5.2	4,916	11.3	15,069	34.7
1962	36,516	2,948		3,910		1,772		3,793		15,125	

CASE SERVICE EXPENDITURES BY CATEGORY

Amount and Percent Each is Of Total Case Service Expenditures

D.R.S.

Fiscal Year	Maintenance & Transportation	Tools, Equipment, Licenses & Other	At Rehab. and Adjustment Centers	At Workshops	Other			
	Amount	%	Amount	%	Amount	%		
1968								
1967	\$154,553	18.3	\$11,368	1.3	\$ 901	.1	\$198,086	23.5
1966	61,714	13.5	20,164	4.4	7,903	1.7	94,282	20.6
1965	50,348	15.1	7,101	2.1	8,008	2.4	54,771	16.5
1964	58,210	17.1	2,790	.8	6,396	1.9	--	--
1963	32,011	12.2	3,325	1.3	9,309	3.6		
1962	33,124		6,748					7,719

S.V.I.

1968									
1967	43,537	24.0	19,622	10.8	8,858	4.9	3,352	1.8	
1966	16,105	14.5	19,348	17.4	4,852	4.4			
1965	6,364	9.7	11,479	17.5	5,200	8.0			
1964	8,910	11.1	20,061	24.9	2,680	3.3			
1963	3,208	7.4	8,435	19.4	1,433	3.3			
1962	6,248		1,498						

DATA ON CASE SERVICES PROVIDED: NUMBER OF CLIENTS, AVERAGE COST, BY CATEGORY

D.R.S.

Fiscal Year	Total Case Services	Diagnostic Procedures		Surgery and Treatment		Prosthetic Appliances		Hospitalization & Convalescent Care		Training and	
		No. of Clients	Average Cost	No. of Clients	Average Cost	No. of Clients	Average Cost	No. of Clients	Average Cost	No. of Clients	Average Cost
1968											
1967	\$844,754	1,620	\$35	124	\$187	209	\$262	27	\$473	994	\$334
1966	458,348	1,191	26	73	146	117	193	16	493	746	272
1965	332,838	1,083	23	33	179	123	165	13	226	682	232
1964	339,833	798	61	56	159	95	161	19	266	671	289
- 1963	261,673	876	37	54	172	100	200	17	310	638	236

S.V.I.

1968											
1967	181,396	381	38	82	212	122	71	40	288	147	368
1966	110,960	247	26	43	344	60	66	33	238	96	393
1965	65,490	188	18	37	191	50	48	27	257	92	246
1964	80,466	171	23	28	235	57	58	24	314	82	334
1963	43,468	145	24	22	214	31	74	18	273	72	209

Table 8.

AMOUNT OF TOTAL EXPENDITURES BY CATEGORY UNDER SECTION 2

General Agency

Fiscal Year	Total Program	Administration		Guidance and Placement		Case Services		Small Business Enterprises		Workshops		Rehabilitation Facilities	
		Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
1968	2,198,245												
1967	1,485,479	69,425	4.7	571,299	38.4	844,755	56.9						
1966	804,921	42,901	5.3	303,672	37.7	458,348	57.0						
1965	607,427	34,161	5.6	240,428	39.6	332,838	54.8						
1964	572,942	30,522	5.3	202,587	35.4	339,833	59.3						
1963	468,088	30,779	6.6	175,636	37.5	261,673	55.9						
1962	441,118	25,063		153,375		262,680							

S.V.I.

1968	388,673												
1967	372,569	27,571	7.4	114,436	30.7	181,396	48.7	49,166	13.2				
1966	193,443	13,251	6.8	69,232	35.8	110,960	57.4						
1965	137,260	7,667	5.6	64,103	46.7	65,490	47.7						
1964	153,414	4,629	3.0	68,319	44.5	80,466	52.5						
1963	114,867	5,129	4.5	66,270	57.4	43,468	37.8						
1962	112,573	5,782		70,275		36,516							

Table 9.

DEPARTMENT OF PUBLIC INSTITUTIONS	LOCATION OF FACILITY	DATE OF REVISED AGREEMENT	ESTIMATED EXPENDITURES	STATE	FEDERAL
Nebraska Psychiatric Institute	Omaha	7/1/68	\$ 60,735	\$ 7,200	\$ 53,535
Norfolk State Hospital VRU	Norfolk	7/1/68	226,125	97,392	128,733
Southeast Psychiatric Clinic	Lincoln	7/1/68	53,069	6,204	46,865
Hastings State Hospital VRU	Hastings	7/1/68	291,045	79,480	211,565
West. Nebraska Psychiatric Clinic	Scottsbluff	7/1/68	31,156	5,096	26,060
Beatrice State Home VRU	Beatrice	7/1/68	157,348	99,748	52,600
Nebraska Boys Training School VRU	Kearney	7/1/68	38,736	9,684	29,052
Lincoln State Hospital	Lincoln	9/1/68	72,976	18,244	54,732
Reformatory VRU	Lincoln	10/1/68	132,800	33,200	99,600
			1,063,990	356,248	702,742
OTHER STATE AGENCIES					
Nebraska Workmens Compensation Court	Lincoln	9/1/68	14,579	4,596	9,983
			1,078,569	360,844	712,725
SCHOOLS					
Omaha Public Schools	Omaha	9/1/68	177,340	44,335	133,005
Omaha Westside Community Schools	Omaha	9/1/68	13,440	6,390	7,050
Grand Island Public Schools	Grand Island	9/1/68	25,131	12,940	12,191
			1,294,480	424,509	864,971

SERVICES FOR THE VISUALLY IMPAIRED

The State Department of Services for the Visually Impaired operates as an agency of the State Department of Public Institutions for the purposes of providing rehabilitation services for persons with visual impairments; and for collecting, interpreting, and disseminating information relating to the causes, prevention, and cure of blindness. The Nebraska Statutes which authorize the program and activities of the agency are Sections 81-101, 83-101.01 to 83-120 inclusive, 83-210 to 83-210.06 inclusive, R.S. 1943, 1965 Cumulative Supplement; and 83-211 to 83-212 inclusive, R.S. 1943.

Interpretation of the Statutes which define the term, blind, include "all persons whose sight is so defective as to seriously limit their ability to engage in the ordinary vocations and activities of life" makes it the duty of the Services for the Visually Impaired agency to serve not only those who are blind, as the term is commonly used and understood; but, also, to serve those with less severe visual defects.

The Statutes also clearly state that services to children with visual defects shall be the responsibility of the State Department of Education from birth until the completion of a suitable program of education. This is interpreted to be the completion of high school or as far toward that goal as the child's abilities will permit, or 21 years of age.

In 1965 the Nebraska Legislature passed a bill which made possible the development of a children's eye care program as a part of Crippled Children's Services in the State Department of Public Welfare.

While some services, such as the lending of talking book machines, are available to young blind children, for the most part, the services of the Blind Agency are provided to older children and adults. A very close working relationship among the various agencies having responsibilities for services for the visually impaired provides uninterrupted and well co-ordinated total-individual services to persons of all ages who are known to need such services.

Blind persons in Nebraska are those whose vision would be less than 20/200 in the better eye with best corrective lens or whose field of vision at its widest diameter is no greater than 20 degrees, plus a large number who have seriously limiting visual defects.

In addition to the State office in Lincoln, district offices of the Nebraska Services for the Visually Impaired are maintained in Ogallala and Omaha. The total staff of the agency consists of the director, a supervisor of rehabilitation, five vocational rehabilitation counselors, three home teachers, a supervisor of small business enterprises, an assistant to the supervisor of small business enterprises, a supervisor of special services, two accounting clerks, three full-time secretaries, and two half-time secretaries. Also available on a consulting basis, are an ophthalmologist who serves as the State medical consultant,

three district medical consultants, and a psychologist. Services of other specialists are purchased as needed.

The Department of Services for the Visually Impaired meets its financial responsibilities through a combination of services provided by joint State-Federal vocational rehabilitation services and State-only financed services.

Cooperative working relationships with the Lions Clubs of Nebraska and the Department of Ophthalmology at the University of Nebraska Hospital continue to make available the resources of the Nebraska Lions Eye Bank and the Low Vision Clinic for sight conservation and restoration.

Volunteer recording of textbook materials by the Casper E. Yost Chapter of the Telephone Pioneers of America in Omaha and employees of the Western Electric Company in Omaha has helped greatly. The women of the Beth El Synagogue of Omaha continue to make a great contribution to the rehabilitation of blind persons through their Braille transcribing services which is also done on a volunteer basis.

Limited use has been made by the Services for the Visually Impaired of the special orientation and adjustment centers for the blind in Minneapolis, Minnesota, and in Topeka, Kansas. Clients of the agency who were in need of intensive services for learning to live as blind persons were sent to these centers for training.

The facilities and programs of Goodwill Industries, Inc., of Omaha, were used quite extensively for adjustment, orientation, evaluation, training, and work adjustment. With the addition of staff with special training and responsibilities for the supervision and direction of these rehabilitation activities for blind persons, the Omaha Goodwill Industries cooperative programs are proving to be of much value in providing rehabilitation services to the blind of Nebraska.

Cooperative agreements for referral of persons who might possibly benefit from the services of the Services for the Visually Impaired continue to work well between the Nebraska Services for the Visually Impaired and such agencies as the Division of Rehabilitation Services in the State Department of Education, the Nebraska School for the Visually Handicapped, the State Department of Labor, the State Department of Public Welfare, Selective Service, public and private schools throughout the state, as well as individual professional persons over the state whose work is related to persons with visual impairments. These relationships are resulting in a continuous and ever-increasing flow of referrals to this agency of persons in need of services. Early referral of persons with visual defects is extremely important for best adjustment to blindness as well as for the best possible chance for sight conservation or sight restoration through medical treatment and care. Delay of referral of persons in the early stages of progressive conditions which lead to blindness often results in permanent blindness.

The agency has increased the number of supervised vending stands in public buildings in Lincoln, Omaha, Hastings, Grand Island, and North Platte from nine to eleven. One of the new stands is a coffee shop type of stand and the other a package stand with vending machines and prepackaged food items. Two existing stands were moved to different locations with greatly improved facilities and increased profit potentials for the operators.

The increase in the revolving fund for improving small business opportunities for the blind also made it possible for some expansion of home industries and caravan sales of blind-made products. The cooperation of Nebraska Lions Clubs made it possible for the blind caravan sales operator to sell blind-made merchandise, earning for himself over \$4,000 annually, and helping to provide a market for merchandise being made by home-bound blind persons.

The Lincoln Braille Club continues to provide rent-free, with all utilities paid, a warehouse and shop space for the home industries and caravan sales program. The shop provides self-employment for one blind person. In addition, three blind persons are self-employed as salesmen and seven blind persons are making products in their homes. Further expansion in all phases of small businesses and home industries is anticipated.

The agency has continued to promote sight conservation through the use of films, lectures, and the distribution of literature on eye care and safety. The agency has also worked closely with the Nebraska Lions Sight Conservation Foundation, the Nebraska Foundation for the Visually Handicapped, the Division of Special Education in the State Department of Education, and the Departments of Health and Public Welfare, as well as many other public and private groups and organizations in promoting sight conservation and prevention of blindness. The result is ever-increasing public awareness of the importance of eye care; medical treatment for prevention, preservation, and restoration of sight; and rehabilitation opportunities for the visually impaired.

Many free or inexpensive aids are made available to persons in need of them through this agency and the many state and nation-wide service agencies and organizations engaged in providing services to blind persons. The agency serves as the coordinating agency for all types of services and aids for persons of all ages and all types of needs arising from visual defects or conditions.

Well over 1,500 of Nebraska's visually impaired citizens were served directly one or more times during the last biennium by Nebraska Services for the Visually Impaired. All of Nebraska's visually impaired citizens are being served by its continuing programs of information on prevention, services and rehabilitation.

The goal of the blind agency is to provide vocational rehabilitation services to Nebraska's blind and visually impaired citizens who are found interested in and eligible for such services and to provide services which are both adequate in quantity and quality.

Technological changes being brought about by science and industry make it essential that an agency constantly change its approaches in providing services which will help blind persons develop their potentials for participating and sharing in the abundant life of today's world.

While most of the staff and funds of the agency are used for vocational rehabilitation services, the fact is that by far the most of Nebraska's blind population are not eligible for or interested in vocational rehabilitation. They are either too young or too old, already suitably employed, or too severely handicapped by afflictions in addition to blindness. However, the chapter on the statewide census reflects a realistic appraisal of the number of Nebraskans needing services from the State Agency responsible for serving this disability category. Special services of many kinds are provided for these persons by the State Agency in cooperation with other agencies both public and private.

One of the most important of these services is that of the home teachers who are blind themselves and who teach such things as communication skills, independent travel techniques with the use of a white cane, homemaking skills, craft work and other leisuretime activities. The reading and writing of Braille as well as typing may be a part of the communications skills which are taught by the home teachers. These crafts and skills, as well as the adjustment to blindness, are taught in the homes of the blind when they are unable to leave their homes for the instruction. The home teachers also give instruction in any or all of these areas to vocational rehabilitation clients of the agency when called upon to do so. The home teachers also train volunteers so that they may assist in transcribing Braille for use by blind persons.

Another very popular service of the agency is the lending and repair of talking book machines for the blind. These machines are provided through an agreement with the Library of Congress. An agreement with the Casper E. Yost Chapter of the Telephone Pioneers of America in Omaha to provide repair service as a volunteer service has enabled the agency to provide a machine for every eligible applicant in the state without any waiting on the part of the applicant, and to replace machines in need of repair as soon as the need for replacement is known to the agency. The Telephone Pioneers also deliver and pick up the machines for users in the Omaha area in person, and handle the mailing of the machines for users in other parts of the state. Four hundred forty-six talking book machines were repaired by the Telephone Pioneers during the biennium without any charge for the service. About 850 talking book machines are in use by blind persons in Nebraska. Close cooperation with the Nebraska Public Library Commission and Library for the Blind provides a complete library service for blind persons in Nebraska.

ESTIMATE FOR OMAHA METROPOLITAN AREA
(Blind and Visually Impaired - 7/1959)

	<u>Est. Pop. 7/1959 Number</u>	<u>Est. Blind</u>	<u>Est. New Blind</u>	<u>Est. Partially Seeing</u>
Under 20 years	165,344	60	6	326
20 to 39 years	116,373	108	4	544
40 to 64 years	116,592	245	21	1,308
Over 65	<u>37,824</u>	<u>456</u>	<u>43</u>	<u>2,500</u>
Total	436,264	872	74	4,690

ESTIMATES OF BLIND POPULATION IN NEBRASKA
(Population 1960 - 1,411,300)

	<u>Est. Pop. 1960 Number</u>	<u>Est. Blind</u>	<u>Est. New Blind</u>	<u>Est. Partially Seeing</u>
Under 20 years	53,488	194	19	1,055
20 to 39 years	376,467	349	13	1,760
40 to 64 years	377,175	793	68	4,231
Over 65	<u>122,360</u>	<u>1,475</u>	<u>139</u>	<u>8,088</u>
Total	1,410,877	(2,821) / 20/200 or less in better eye with correction or angle of 20 or less	239	(15,172) / 20/70 to 20/200 with best correc- tion or progressive conditions

In January, 1960, the Social Planning Unit of the United Community Services of Omaha, Nebraska completed a report in regard to the number of blind and partially sighted living in Omaha and the metropolitan area.

The National Society for the Prevention of Blindness provided the committee from the United Community Services with estimates for a city of 400,000 size.

The figures were applied to the population of Omaha's Standard Metropolitan Area. A population of 306,600 was used for the central city and a population of 129,664 for outside the central city. These figures were estimated as of July 1, 1959 and were based on special censuses with estimates by State and Local Agencies as well as estimates by the Statistical Bureau of the Metropolitan Life Insurance Co.

The tables listed on page 80 were the estimates made by the Social Planning Unit of the United Community Services of Omaha and are useful in trying to give an indication of prevalence of blindness in this state.

Another resource that is helpful in estimating blind prevalence rates is Ralph G. Hurlin, Ph. D., who is a recognized national authority on the incidence of blindness in the general population. Dr. Hurlin, in an article, "Estimated Prevalence of Blindness in the United States and in Individual States, 1960," indicated the estimated prevalence of blindness in Nebraska as 2,550. This estimate was based on an estimated population of the state of 1,414,000 for the year 1960. Dr. Hurlin listed an estimate of 1.79 blind persons in Nebraska per 1,000 population. He listed 3 factors underlying the estimates. They were:

- (1) 11.6 per cent of the population were age 65 or over;
- (2) 2.6 per cent of the population were nonwhite; and
- (3) the infant death rate, average 1948-52, was 24.6.

PRODUCTION RECORD OF
DEPARTMENT OF SERVICES FOR THE VISUALLY IMPAIRED

Table 2, page 65, shows that for the period involving fiscal years 1961 through 1968, 1,112 blind or people who had serious visually impaired problems were accepted for services by the Services for the Visually Impaired. During fiscal year 1968, the agency accepted 180 new cases. During this 8 year period the agency has served 2,360 people and has successfully rehabilitated 694. In this last fiscal year the total case load for the agency was 487 with 143 of this number rehabilitated successfully. In this last fiscal year the average cost to rehabilitate a blind person in Nebraska was \$2,717. Over an 8 year period the mean cost was \$2,154, with the range running from a low of \$1,617 to the high of \$3,029 which was incurred in the fiscal year 1967. However, the 1967 fiscal year was an unusual year for the blind agency since more expenditures were incurred due to the establishment of small business enterprises and the development of a new cafe type vending stand, plus the involvement of the agency in the home industries for the blind. It apparently costs more to rehabilitate a person with blindness than other disease entities for which the rehabilitation agencies have approved cost figures. However, there is a basic truism that is found in both the blind agency and the general agency. It costs less money to the state, to the family, and to all concerned to rehabilitate the handicapped than it does to allow a person to remain in a dependent state.

The figures that have been used to estimate the average cost per rehabilitation based on Section 2 expenditures are figures provided in this category by the Vocational Rehabilitation Agency of Washington, D. C. It should be noted that the rehabilitation process can take a very short time and be very inexpensive or involve a period of many years and be very expensive, and that this accrued average of cost indicates to the project office that both of the state rehabilitation programs have been spending the rehabilitation tax dollars very wisely and getting the maximum benefits from each dollar invested. One of the best measures of how rehabilitation programs are serving the handicapped of this state is to compare some key factors that rehabilitation authorities feel will tell the story of that State's efforts in rehabilitation. These figures are accrued and interpreted in the federal office of the Vocational Rehabilitation Administration. In the previous pages a breakdown has been given for the production figures for each agency.

Table 5, page 68, has been developed and shows State rehabilitation statistics combining the production record for both the Division of Rehabilitation Services and the Services for the Visually Impaired. Information on an 8 year period has been developed in each category whenever possible. Some of the figures have not been published by the federal office as yet and thus are not available at this time. Each year, the two agencies have been progressively serving more people, accepting 971 cases in 1961 and 2,402 in 1968. During the period 1961 through 1968, a total of 10,923 handicapped persons were accepted for service by the two state rehabilitation agencies. In this 8 year period the two agencies served 27,936 people with 5,595 handicapped Nebraskans being served in 1968.

In this period of almost a decade, 6,928 handicapped Nebraskans were successfully rehabilitated, with 1,410 rehabilitated in 1968. The costs for both agencies have been combined to determine the average cost per rehabilitation. In 1968 the mean cost per rehabilitation based on total expenditures under Section 2 funding was \$1,834. The mean cost through the entire 8 year period was \$1,145. An index of how well the state programs serve the handicapped citizens of Nebraska can be measured by the number served per one hundred thousand population. Of the fifty(50) states and three territories providing rehabilitation programs, Nebraska has consistently been average to better than average in serving its handicapped people. In 1967 as compared to 1966, Nebraska made a dramatic increase in number of persons served per one hundred thousand population from 245 to 1966 to 315 in 1967. This changed its rank order position from 28 to 25. The interpretation of ranking should be that the best achiever is classified as No. 1 in serving its people and No. 53 would be at the opposite end of the scale. Another measure that is used in evaluating the production record of a state agency is: Number of rehabilitations achieved per one hundred thousand population. From 1965 through 1967 Nebraska continued ranking number 30 in the nation, but in 1967 rehabilitated 80 persons per one hundred thousand population as compared to 62 per one hundred thousand population rehabilitated during the previous year.

Table 6, page 69, gives a breakdown for both of the state agencies in reference to the costs of operating the rehabilitation programs in the state. Column 2 shows the amount of state-federal money that was expended in the support program. In the 8 year history the cost of the support program compared to the total number rehabilitated in the state by both the general agency and the blind agency shows that it is costing more money each year to rehabilitate handicapped people.

Table 7, page 70, has been prepared since it gives a breakdown of the case service expenditures by category. This again shows that it is costing more in most cases in the diagnostic area which includes medical examination, psychological testing, medical services, as well as in the training and training materials, the maintenance grants provided the rehabilitation clients and all other service categories. Again it should be noted that the earlier a handicapped person is served, the less complicated and the less expensive and the more successful his rehabilitation will be.

SERVICES FOR THE VISUALLY IMPAIRED

IN-SERVICE TRAINING PROGRAMS

A meeting was recently held with the Supervisor of Vocational Rehabilitation of the Services for the Visually Impaired for Nebraska to review the in-service programs it provides its staff.

It was determined that \$1,000 has been budgeted for in-service training of the professional staff of the blind agency. In addition to this money a small amount of Section 2 money has been budgeted for staff meetings. A portion of these meetings are dedicated to in-service training.

In the past two years, the agency has provided twelve staff training sessions. Some of the areas or items covered have been instruction and discussion on new laws and regulations as well as agency policies and procedures.

Resource people have made presentations to the staff whenever possible. They have included representatives from Welfare, the Division of Employment, Workmen's Compensation, etc.

Whenever possible, the counselors and the staff members are given the opportunity to attend regional as well as national training programs as they pertain to rehabilitation.

Annually the agency has a joint staff meeting with a nearby state. The regional office has participated in these meetings whenever possible.

Almost all the counselors on the staff of the blind agency have attended the orientation training that is offered for new counselors at the University of Missouri at Columbia. As part of the orientation program provided by the blind agency, each new counselor spends two weeks in the State office. During this period, the new counselor becomes acquainted with the agency's State Plan, Manual of Procedures, as well as other training materials.

During this training of the new member of the professional staff, several hours each day are spent in a one-to-one relationship between the trainer and trainee during which time a review is made of the material covered and questions are answered in a realistic way.

When ready each new counselor spends several days with field counselors. This provides the new counselor with an opportunity to observe the client being served and the field counselor in action. The field exposure includes visiting the various facilities in that part of the state and some important contacts. One full day is spent with the Business Enterprises Supervisor, the orientation officer and the placement specialist.

The agency provides the counselor the opportunity to take one three-hour course at college level. The agency will pay for the cost of tuition as well as the cost of the books; however, the training must be taken after working hours and be directly applicable to the job. By comparison, the general agency will allow a professional staff member reasonable time away from the job to take a course at college level but the individual must pay for the cost of tuition and books.

RECOMMENDATION: That consideration be given by the Director of the Services for the Visually Impaired to liberalize the college training provision for the professional staff and provide the opportunity for the staff member to enrolling a three-hour course at university level during working hours. (This would allow for an upgrading of the staff members and provide better services to the blind of this State.)

HOME TEACHING SERVICES FOR THE VISUALLY IMPAIRED

The Services for the Visually Impaired agency has provided home teaching services to clients for many years by having a field teacher visit clients at their residences. The agency in past years was serving fewer clients and could afford the approach of having a home teacher visit each client's home. However, as the number of blind people being served by the agency has increased, time has become very precious and a better method is sought to train these cases.

Quality adjustment training has to be provided these blind people in order for them to learn independent living skills. One approach that has been suggested that seems to have real merit is that of having each district office where there is a home teacher assigned to expand the office facilities to include three rooms which could be utilized for teaching space. One of these rooms would include a kitchen suitably equipped and a combination utility room with a washer and dryer. The second room should contain living room and bedroom furniture for teaching purposes while the third room could be a conference room which could also serve as a group training room for the blind supervised by the orientation officer and could also be used as a conference room and library for the staff.

If such a field office adjustment center could be established, then clients for example who live in Omaha and in the small towns surrounding Omaha could be transported to the office by volunteers or paid workers, and be involved in group or in individual training sessions wherein they would learn daily living skills, homemaking skills, Braille, typing, handcrafts, orientation, and mobility. Scheduling could be arranged so that the individual could be seen separately or in a group. This would allow the orientation officers, who are commonly referred to as home teachers, the opportunity to serve almost twice as many blind cases each week as they are now serving.

It has been that the overall period it takes a client to complete the program of home teaching services runs an average of nine to twelve months for most subjects. However, this time could be reduced to approximately four to six months which then would allow the specialist in charge of this teaching program to extend the services to more blind people in the state.

At the present time the orientation counselor spends a great deal of time in travel and there are many interruptions that occur in the client's home that further can reduce the efficient use of the teacher's time. In a center where the teaching sessions would be held the equipment would be the same and a more classlike environment could be instituted. By locating the center in the district office this would cause the blind person to leave home to take advantage of the training. This leaving of the home for only a short period of time is important in helping the client to increase his enthusiasm, motivation, and seriousness of intent. It would take a blind person from a known environment to an

unknown environment which in itself would be an excellent training situation. Exposure of the clients in working with groups and especially in group guidance sessions would allow the clients to compare themselves with the functioning and philosophy of fellow blind clients who are struggling with similar feelings of inadequacy and fears. The possibility of group discussions to be held by the orientation officer would be an innovative aspect of the blind agency.

The addition of two or three rooms would be an added expense to the agency but the important aspect to consider would be that more blind clients would be provided services plus the fact that this added space could be used by the regular staff counselors for conferences, for use as a library, etc.

Another observation that has been made is that the orientation officer needs to be allowed to build up a supply of handcraft items. Considerable time is spent at this point by the orientation officer having to shop for a small supply of handcraft items for each client.

RECOMMENDATION:

THAT IN EACH OF THE DISTRICT OFFICES WHERE A BLIND HOME TEACHER IS ASSIGNED THE OFFICE SPACE BE INCREASED TO PROVIDE THREE EXTRA ROOMS FOR TEACHING SPACE. ONE ROOM SHOULD CONTAIN TYPICAL KITCHEN UTILITIES, THE SECOND ROOM BEDROOM AND LIVING ROOM FURNITURE, AND THE THIRD SHOULD BE OUTFITTED AS A COMBINATION CONFERENCE ROOM AND TRAINING ROOM. THIS RECOMMENDATION WOULD REQUIRE THAT THE STATE OFFICE FOR THE SERVICES FOR THE VISUALLY IMPAIRED WHICH ALSO FUNCTIONS AS A DISTRICT OFFICE BE PROVIDED MORE SPACE OR BE LOCATED OUTSIDE THE CAPITOL BUILDING. A THIRD DISTRICT OFFICE OF THIS TYPE WITH APPROPRIATE PERSONNEL SHOULD BE LOCATED IN THE WESTERN HALF OF THE STATE.

It has been pointed out that regardless of the cost of providing vocational rehabilitation services to all who are eligible for such services, that it is in the interest of the state and more economical to the state to serve handicapped persons as the need arises. It has already been noted that the mean rehabilitation cost in Nebraska is consistently less than the national cost mean.

The Services for the Visually Impaired has been relatively consistent in rehabilitating about ten per cent of the total number of persons rehabilitated in the state each year. The projected need of rehabilitations for 1975 is 3800 to 4500 persons per year.

The rehabilitation agencies have found by experience that on the average one out of four persons being served by the agency is rehabilitated by the end of each year. Based on this ratio, the Services for the Visually Impaired would need to increase their caseload to between 1500 to 1800 persons by the year 1975.

To accomplish this objective would require the addition of (14) fourteen counselors, (4) four other professional workers as well as (10) ten additional clerical personnel. This would require a total budget for this agency of approximately \$1,000,000.00 of which (80) eighty per cent would be provided by federal funds. However, the important issue is that a larger number of the blind and the severely visually impaired would be served properly.

The Services for the Visually Impaired at this time has one counselor serving (32) thirty-two counties with an estimated population of 236,031 persons. One county in his area is probably one of the largest in the entire United States. It covers 5,982 sq. miles. His area covers 39,258 sq. miles or approximately 26 per cent of the state.

IT IS RECOMMENDED THAT THE SERVICES FOR THE VISUALLY IMPAIRED SHOULD HAVE A MINIMUM OF (1) ONE COUNSELOR, (1) ONE HOME TEACHER, (1) ONE SUPERVISOR OF SPECIAL SERVICES, AND (1) ONE FULL-TIME SECRETARY TO STAFF THE WESTERN OFFICE OF THE STATE.

The District Office mentioned above is currently located in Ogallala, Nebraska. The location of a District Office should be based on its being reasonably central to the people it serves. In addition, it should be located so that the professional personnel are near other agency offices such as the Division of Employment Security, the Social Security Office, Mental Health Clinics, Ophthalmologists, etc. The town of Ogallala doesn't satisfy any of these requirements.

The costs of relocating this office would be minimal in comparison to the improvement of services that would be provided to the blind and severely visually impaired of that section of the state.

IT IS RECOMMENDED THAT THE SERVICES FOR THE VISUALLY IMPAIRED RELOCATE ITS WESTERN OFFICE TO NORTH PLATTE, NEBRASKA.

Two of the three offices of the Services for the Visually Impaired have been observed by the professional staff of the project office over a several month period with the purpose of learning more about the operation the office so that observations of a positive type could be made.

It has been observed that in at least one office that a staff member has been assigned to work in the capacity of a District Supervisor but has never been given the authority to make decisions commensurate with his assigned responsibilities. A public office should have one staff person working in it that is responsible for everything that happens in the office. This observation includes the state office operation as well. Full authority needs to be given the administrator to perform his job for which he is hired. Several recommendations will be made based on this several month period of observation of the District Office and State Office operation.

RECOMMEND THAT STAFF MEMBERS WORKING IN THE CAPACITY OF DISTRICT SUPERVISORS BE GIVEN THIS TITLE AND FULL AUTHORITY TO FUNCTION IN THIS CAPACITY.

RECOMMEND THAT A TIME STUDY BE COMPLETED ON ALL THE OFFICES OF THE SERVICES FOR THE VISUALLY IMPAIRED. THIS STUDY SHOULD COVER THE ACTIVITIES OF THE PROFESSIONAL AND THE CLERICAL STAFF ALIKE.

RECOMMEND THAT THE VENDING STANDS THAT ARE NOW BEING CONTROLLED BY THE SERVICES FOR THE VISUALLY IMPAIRED BE SUPERVISED ONLY BY THE PROFESSIONAL PERSON OR PERSONS DESIGNATED THIS RESPONSIBILITY BY THE AGENCY.

RECOMMEND THAT THE OPERATORS OF THE VENDING STANDS KEEP THEIR OWN BOOKS SUBJECT TO AUDIT BY THE STAFF OF THE AGENCY. THIS WOULD ALLOW FOR THE ELIMINATION OF ONE ACCOUNTING CLERK FROM THE STATE STAFF OF THE SERVICES FOR THE VISUALLY IMPAIRED.

The following table was prepared by the Director of the Services for the Visually Impaired and the staff of the Project Office. It reflects the production record of the agency in critical statistical areas and projects the staff and funding requirements of the agency if it is to serve this number of handicapped citizens.

The Services for the Visually Impaired has become known in this state for its conservatism in staffing and funding requests. The consultant that was utilized by the project office stated in his reports and correspondence with the project office that the Directors of the Rehabilitation programs might find it difficult to make good solid projections that would adequately meet the needs of the handicapped people of this state since the pattern has been set for so long a period to think in terms of a minimal program.

The following chart is based on realistic projections and should provide an excellent guideline for the needed expansion of the blind agency.

NEBRASKA SERVICES FOR THE VISUALLY IMPAIRED

Caseload Statistics
and
Projections

NEBRASKA SERVICES FOR THE VISUALLY IMPAIRED

Caseload Statistics and Projections

	1961-62	1962-63	1963-64	1964-65	1965-66	1966-67	1967-68	1968-69	1969-70	1970-71	1971-72	1972-73	1973-74	1974-75
Total persons provided vocational rehabilitation services	152	206	267	278	342	470	487	575	745	915	1,085	1,255	1,425	1,600
Total number of cases closed, "Rehabilitation Services Complete"	57	54	73	82	97	123	143	160	185	225	270	310	350	400
Active cases remaining at end of fiscal year	82	134	173	161	222	307	306	340	450	550	650	750	850	960
Average expenditure per person served	\$958	\$740	\$737	\$661	\$660	\$852	\$714	\$800	\$840	\$880	\$920	\$960	\$1,010	\$1,060
Total expenditures of agency in providing services	\$145,613	\$152,426	\$196,904	\$183,678	\$225,864	\$400,626	\$347,638	\$460,000	\$625,000	\$800,000	\$998,000	\$1,200,000	\$1,450,000	\$1,700,000
Total number of full-time staff positions in agency	18	18	18	18	19 1/2	19 1/2	22	23	25	28	32	37	43	50

The above statistics are based upon actual performance through fiscal 1967-68 and upon best estimates from 1967-68 through 1975-76.

PROPOSAL FOR CONSOLIDATION OF STATE
VOCATIONAL REHABILITATION AND SERVICES TO THE BLIND*

Preface

The problem and conflict over the most effective system of providing services is as old as history and has its roots in the very natural tendency of special concern and the vested interests which arise from this concern. It is further compounded by the explosion of knowledge and the consequent growth in specialization. Unfortunately, this issue is difficult to resolve rationally not only because of the logic of the arguments which are made, but by the fervor of emotional involvement that usually exists.

Historically and philosophically we have vacillated, many times, from one extreme to the other and both persons and programs have suffered. In any event resistance to changing conditions and misunderstanding of the nature of the total situation have made rational solutions difficult. It is fair to say, I think, that during the past 50-75 years the trend has been from the general consolidated operation to specialization and separation and now to a more integrated approach both as to administration and service.

Administrative Argument

1. Reduce duplication of administrative offices, supervisory staffs, travel, personnel recruitment in service training and hence costs making more money available for service.

2. Provide for consultative services on a more coordinated basis.

3. Permit specialization of services and programs in all areas of disability where required or justified.

4. Marshall and utilize all the resources available for all the disabled in a more equitable and effective fashion.

5.. Special services for the blind operating independently has no more reationalization administratively than one for the deaf, the mentally retarded, the amputee, or many other disabilities each requiring special knowledge, skill and treatment.

*This proposal prepared by Mr. Philip H. Vogt at the request of the Executive Committee of the Policy Board.

Service Argument

1. Recognition of the individual rather than the disability.
2. The common denominators that characterize all disabilities.
3. The psycho-somatic relationships of all pathology.
4. The fact that the majority of disabled and handicapped have more than one disability. We speak increasingly of multi-problem, multi-disability, etc.
5. Increasingly, training is taking place in education, the professions and even business which provide understanding of the totality, the wholeness, the interrelationships.
6. The clinic approach with inter-disciplinary participation within a single administrative structure is demonstrating its effectiveness in improving the quality of service and minimizing duplication of operation and excessive costs. Ex. The general hospital - recent creation of the Family Service Section.
7. The reference to what does or does not exist in other states has little validity or relevance as to what is the best way. Rather it could simply demonstrate the persistence of tradition in the face of changing conditions.

Limitation of Chronically Disabled
School Age Children Reported By Regions
N=40,516

	0-4	5-15	Over 16	1	2	3	4	5	6	7
1. Lincoln	848	6,414	1,132	376	1,696	2,640	1,513	1,226	377	566
2. Omaha	1,629	11,928	2,441	1,085	2,984	5,151	2,304	3,118	543	813
3. Alliance	108	414	162	54	162	252	36	126	18	36
4. Beatrice	77	1,078	231	77	154	462	308	308	-	77
5. Fremont	300	1,680	180	480	360	420	60	540	180	120
6. Grand Island	140	1,539	-	-	280	-	839	420	140	-
7. Hastings	57	963	171	57	114	454	282	227	-	57
8. Kearney	417	1,460	104	104	417	313	521	626	-	--
9. McCook	71	474	165	47	95	332	46	119	24	47
10. Norfolk	199	1,044	150	397	150	348	-	398	50	50
11. North Platte	198	825	264	99	231	495	99	264	33	66
12. O'Neill	76	515	57	152	76	133	59	171	38	19
13. Scotts Bluff	156	936	416	104	312	676	52	208	52	104
14. So. Sioux City	161	803	161	230	92	321	114	299	46	23
15. Valentine	93	217	62	31	155	62	31	93	-	-
Total:	4,530	30,290	5,696	3,293	7,278	12,059	6,264	8,143	1,501	1,978

A Comparison of the Distributions of Disabilities of the
Nebraska Sample With Those Reported by the National Health Survey

<u>Disability</u>	<u>N.H. Survey</u>	<u>V.R.A. Code</u>	<u>Nebraska Survey Result</u>			<u>Total</u>
			<u>Primary</u>	<u>Secondary</u>	<u>Tertiary</u>	
Visual Impairment	10368	1--	12546	2831	229	15755
Hearing Impairment	4058	2--	5565	3982	879	10426
Orthopedic						
Deformity and		3--)				
Amputations	62883	4--)	37959	6691	1328	45978
Emotional		50-,				
Disorders	14308	51-, 52-	12933	696	125	13754
Mental						
Retardation	-	53-	8808	881	-	9689
Other Neoplasms	3690	6--	1433	474	-	1907
Allergies, Endocrine						
System, Metabolic						
Diseases	19101	61-	24126	3541	2335	30002
Diseases of						
Blood and						
Blood Forming						
Organs	-	62-	1302	-	-	1302
Other Specified						
Disorders of the						
Nervous System	7577	63-	3984	239	-	4223
Cardiac and						
Circulatory						
Conditions	55019	64-	35960	4332	771	40914
Respiratory						
Diseases	5111	65-	5417	921	305	6643
Disorders of the						
Digestive System	18085	66-	2834	1463	1384	5681
Conditions of the						
Genito Urinary						
System	9399	67-	810	288	-	1098
Speech						
Impairments	-	68-	4451	662	-	5113
Disabling Diseases						
and Conditions						
N.E.C.	-	69-	1151	354	-	1505
Social, Economic						
and Educational						
Deprivation	-	700	1879	636	-	2515
Total:	209599		161158	27991	7356	196505

Primary Disability V.R.A. Code 2 Hearing Impairment N-5565
Secondary Disabilities N-820 %age 14.7

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
125	15.2	13	Blind One Eye
258	31.5	61	Allergic, Endocrine System Etc.
437	53.3	64	Cardiac and Circulatory Disorders

Tertiary Disabilities N-274 %age 33.4 4.9

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
149	18.2	64	Cardiac and Circulatory Disorders
125	15.2	65	Respiratory Diseases

Primary Disability V.R.A. Code 3 Orthopedic Deformity N-36391
Secondary Disabilities N-6706 %age 18.3

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
607	9.1	1	Blindness
666	9.9	2	Hearing Impairments
1696	25.3	3	Orthopedic Impairments
229	3.4	4	Amputations
22	.3	52	Mental Disorders
652	9.7	53	Mental Retardation
458	6.8	61	Allergic, Endocrine System Etc.
135	2.0	63	Epilepsy and Other Disorders of the Nervous System
1094	16.3	64	Cardial and Circulatory Conditions
354	5.3	65	Respiratory Disorders
157	2.3	66	Disorders of the Digestive System
229	3.4	69	Diseases of the Skin
407	6.1	70	Social, Educational and Economic Deprivation

Tertiary Disabilities N-1266 %age 18.9 3.5

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
229	3.4	1	Blindness
125	1.9	2	Hearing Impairments
499	7.4	61	Allergic, Endocrine System, Etc.
413	6.2	66	Disorders of Digestive System

Primary Disability V.R.A. Code 10-11 Blindness N-8204
Secondary Disabilities N-2410 %age 29.4

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
229	9.5	20	Deafness
687	28.5	22	Hearing Impairment
607	25.2	30	Orthopedic Deformity
376	15.6	61	Allergic, Endocrine System Etc.
511	21.2	64	Cardiac and Circulatory Disorders

Tertiary Disabilities N-362 %age 4.4

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
133	5.5	64	Cardiac and Circulatory Condition
229	9.5	66	Disorders of Digestive System

Primary Disability V.R.A. Code 12-13-14 Blind One Eye
Other Visual Impairment N-4342 Secondary Disabilities N-1503 %age 34.6

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
149	9.9	64	Cardiac and Circulatory Conditions
867	57.7	22	Hearing Impairment
258	17.2	61	Allergic, Endocrine System Etc.
229	15.2	70	Social, Economic, Educational Deprivation

Tertiary Disabilities N-417 %age 9.6

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
133	31.9	30	Orthopedic Deformity
149	35.7	40	Amputation
135	32.4	64	Cardiac and Circulatory Conditions

Primary Disability V.R.A. Code 50-51-52 Mental
Psychoneurotic and Personality Disorders
Secondary Disabilities N-2104 %age 16.3

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
605	28.8	12	Visual Impairment
501	23.8	3	Orthopedic Deformity
354	16.8	52	Mental Psychoneurotic and Personality Disorders
509	24.2	61	Allergic Endocrine System Etc.

Tertiary Disabilities N-376 %age 17.9 2.9

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
376	17.9	61	Allergic Endocrine System Etc.

Primary Disability V.R.A. Code 53 Mental Retardation N-8808
Secondary Disability N-1479 %age 16.8

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
229	15.5	2	Hearing Impairment
229	15.5	3	Orthopedic Deformity
313	21.1	61	Allergic Endocrine System Etc.
250	16.9	64	Cardiac and Circulatory Conditions
229	15.5	66	Disorders of the Digestive System
229	15.5	68	Speech Impairments

Tertiary Diagnosis N-354 %age 23.9 4.0

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
125	8.4	3	Orthopedic Deformity
229	15.5	61	Allergic Endocrine System Etc.

Primary Disability V.R.A. Code 60 N-1433
Secondary Disability

None Given

Primary Disability V.R.A. Code 61- Allergic,
Endocrine System, Metabolic and Nutritional Disorders N=24,126
Secondary Disabilities

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability N=2420 10.%</u>
591	24.4	3--	Orthopedic Deformity
229	9.5	53-	Mental, Retardation
125	5.2	61-	Allergic, Endocrine System, Etc.
638	26.4	64-	Cardiac and Circulatory Conditions
184	7.6	65-	Respiratory Diseases
504	20.8	66-	Disorders of Digestive System
149	6.2	68-	Speech Impairments

Tertiary Disabilities N=979 40.5% 4.1%

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
216	8.9	3--	Orthopedic Deformity
354	14.6	64-	Cardiac and Circulatory Conditions
180	7.4	65-	Respiratory Disorders
229	9.5	66-	Disorders of the Digestive System

Primary Disability V.R.A. Code 62- Diseases of the Blood and
Blood-Forming Organs N=1302
Secondary Disability

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability N=149 11.4%</u>
99	66.4	3--	Orthopedic Deformity
50	33.6	61-	Allergic, Endocrine System, Etc.

Primary Disability V.R.A. Code 63- Epilepsy and Other
Disorders of the Nervous System
N=1302

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability N=298 7.5%</u>
149	50.0	22-	Hearing Disorders
149	50.0	68-	Speech Impairments

Primary Disability V.R.A. Code 64
Cardiac and Circulatory Conditions N-35,960
Secondary Disability N-7697 %age 21.4

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
378	4.9	1	Blindness
600	7.8	12	Visual Impairment
1155	15.0	2	Hearing Impairments
2717	35.3	3	Orthopedic Deformities
135	1.8	52	Other Mental Disorders
125	1.6	6	Other Conditions Resulting From Neoplasms
614	8.0	61	Allergic Endocrine System Etc.
867	11.3	64	Cardiac and Circulatory Conditions
284	3.7	65	Respiratory Disease
409	5.3	66	Disorders of the Digestive System
288	3.7	67	Conditions of the Genito-Urinary System
125	1.6	69	Diseases and Conditions of the Skin and Cellular Tissue

Tertiary Disability N-3179 %age 41.3 8.8

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
605	7.9	22	Hearing Impairments
705	9.2	3	Orthopedic Deformities
125	1.6	52	Other Mental Disorders
1231	16.0	61	Allergic Endocrine System Etc.
513	6.7	66	Disorders of the Digestive System

Primary Disability V.R.A. Code 65 Respiratory Diseases N-5417
Secondary Disability N-1555 %age 28.7

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
149	9.6	1	Blindness
288	18.5	14	Visual Impairment
22	1.4	3	Orthopedic Deformities
229	14.7	6	Other Malignant Neoplasms
503	32.3	61	Allergic Endocrine System Etc.

Tertiary Disability N-149 %age 2.8 9.6

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
149	9.6	2	Hearing Impairment

Primary Disability V.R.A. Code 66- Disorders of the
Digestive System N=2834
Secondary Disability N=99 3.5%

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
77	77.8	61-	Allergic, Endocrine Systems, Etc.
22	22.2	64-	Cardiac and Circulatory Disorders.

Primary Disability V.R.A. Code 67- Conditions of the Genito
Urinary N=810 System
Secondary Disability N=250 30.0%

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
125	48.0	60-	Other Malignant Neoplasms
130	52.0	66-	Disorders of the Digestive System

Primary Disability V.R.A. Code 68- Speech Impairment N=4451
Secondary Disability N=229 5.1%

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
125	54.6	52-	Other Mental Disorder
104	45.4	63-	Epilepsy and Other Disorders of the Nervous System

Primary Disability V.R.A. Code 69- Disabling Conditions N.E.C. N=1151
Secondary Disability N=133 11.6%

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
99	74.4	65-	Respiratory Diseases
34	25.6	66-	Disorders of the Digestive System

Primary Disability Code 700 Social, Economic and Educational
Deprivation N=1879
Secondary Disability N=139 7.4%

<u>N</u>	<u>%age</u>	<u>V.R.A. Code</u>	<u>Disability</u>
79	56.8	13-	Visual Impairment
50	43.2	52-	Other Mental Disorders

Number of Chronically Disabled
Persons Indicating Services From Various
Agencies and Private Resources
N-87,269

	<u>Number</u>	<u>%age</u> *
1. Medical, Surgical and/or Hospital	83,514	95.7
2. Provision of Artificial Limbs, Hearing Aids, Glasses and other Prosthetic Appliances	14,095	16.2
3. Dental Services and Dentures	11,637	13.3
4. Psychological Testing	7,081	8.1
5. Psychiatric Services Including Psychotherapy	6,663	8.0
6. Training For A Job	6,389	7.3
7. Counseling and Guidance	5,596	6.4
8. Assistance in Finding A Job	5,579	6.4
9. Physical, Occupational, and Speech Therapy	4,437	5.1
10. Planning for a Job	3,236	3.7

* Percentages Do Not Add to 100.0 Because of Overlapping Classifications.

Source Of Income Reported By Disabled

1. Wages, Wife's Wages and Family Income	
<u>Number Reporting</u>	<u>Source</u>
20,627	Wages
6,400	Wife's Earning
4,294	Wages and Wife's Earnings
21,947	Earnings of Other Family Members
6,467	Wages and Earnings of Other Family Members
357	Wife's Earnings and Earnings of Other Family Members
230	Wages, Wife's Earnings, Earnings of Other Family Members
<u>60,322</u>	Total-Wages; Wife's and Family Income
<u>60,325</u>	Not Reporting Above Sources
120,647	Total Disabled (Adult)
2. Pensions and Social Security	
28,923	Social Security
2,552	Veterans Pension
4,687	Private Insurance/Company Pension
617	Vets Pension; Private Insurance/Company Pension
4,346	Vets Pension; Social Security
7,419	Private Insurance;Company Pension; Social Security
<u>1,149</u>	Vets Pension; Private Insurance/Company Pension; Social Security
49,693	Total - Pensions and Social Security
70,954	Not Reporting Above Sources of Income
120,647	Total Disabled (Adult)
3. Rent, Interest; Workmen's Compensation; Unemployment Insurance	
864	Unemployment Insurance
127	Workmen's Compensation
460	Unemployment Insurance; Workmen's Compensation
19,548	Rent/Interest
290	Rent/Interest; Unemployment Insurance
<u>21,289</u>	Total - Rent, Interest; Compensation
<u>99,358</u>	Number Not Reporting Above Sources of Income
120,647	
4. Miscellaneous Sources of Income	
11,714	Farm or Ranch Income
152	Alimony
4,071	Welfare
2,265	Income From Business
2,446	Retirement Income (Miscellaneous Sources)
230	Tuition
595	Subsistence While in Training
136	Income From Roomers
<u>21,510</u>	Total - Miscellaneous
<u>99,037</u>	Number Not Reporting Above Sources of Income
120,647	Total Disabled (Adults)

STATE LEVEL

Characteristics	Population Est. 1967	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS					Total
			No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity		
National	200,000,000	111,800,000	63,800,000	6,800,000	13,200,000	4,600,000	24,600,000	
State	1,506,754	842,275	479,148	51,299	99,446	34,655	185,340	
Region								
County								
Visual Impairments				1,486	4,276	4,506		
Hearing Impairments				768	1,691	1,560		
Diabetes				820	2,287	1,421		
Heart Conditions				5,584	15,712	8,458		
Vascular				6,352	13,525	4,853		
Cancer								
Malignant								
Neoplasms				*	796	901		
Benign and								
Unspecified								
Neoplasms				512	994	451		
Mental and Nervous								
Conditions								
Respiratory				3,637	6,961	3,570		
Gastro Intestinal				5,533	10,044	3,882		
Genito-Urinary				3,945	9,945	4,021		
Arthritic Rheumatism				2,459	4,873	1,976		
Other Diseases of Muscles,				5,943	15,712	5,858		
Bones, Joints								
Orthopedic and Neurologic				2,203	3,680	763		
Mental Retardation - Educable -				8,965	19,094	7,557		
Trainable -								
Severe -								
Economically, Educationally								
and Socially Deprived								
							220,438	
							16,273	
							301	
							263,262	

REHABILITATION DISTRICT 1 OMAHA

Characteristics	Population Est. 1966	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS					Total
			No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity		
National	196,725,270	109,969,426	62,558,636	6,688,659	12,983,868	4,524,681	24,197,208	
State	1,516,044	847,469	482,102	51,545	100,059	34,869	186,473	
Region	538,679	301,122	171,300	18,315	35,553	12,390	66,078	
County								
Visual Impairments				531	1,529	1,610		
Hearing Impairments				274	604	558		
Diabetes				293	818	508		
Heart Conditions				1,996	5,617	3,023		
Vascular				2,271	4,835	1,735		
Cancer				*	284	322		
Malignant Neoplasms				183	356	161		
Benign and Unspecified Neoplasms				1,300	2,488	904		
Mental and Nervous Conditions				1,978	3,591	1,388		
Respiratory				1,410	3,555	1,437		
Gastro Intestinal				879	1,742	706		
Genito-Urinary				2,124	5,617	2,094		
Arthritic Rheumatism				788	1,135	273		
Other Diseases of Muscles, Bones, Joints				3,205	6,826	2,701		
Orthopedic and Neurologic								
Mental Retardation -								
Educable -							78,809	
Trainable -							5,818	
Severe -							108	
Economically, Educationally and								
Socially Deprived							94,766	

REHABILITATION DISTRICT 2 LINCOLN

Characteristics	Population Est. 1966	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS					Total
			No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability to Do Major Activity		
National	196,725,270	109,969,426	62,558,636	6,688,659	12,985,868	4,524,081	24,197,208	
State	1,516,044	847,469	482,102	51,541	100,059	34,869	186,473	
Region	362,300	202,526	115,211	12,318	23,912	8,333	44,563	
County								
Visual Impairments				357	1,028	1,083		
Hearing Impairments				185	407	375		
Diabetes				197	550	342		
Heart Conditions				1,343	3,778	2,033		
Vascular				1,527	3,252	1,167		
Cancer								
Malignant Neoplasms				*	191	217		
Benign and Unspecified Neoplasms				123	239	108		
Mental and Nervous Conditions				875	1,674	608		
Respiratory				1,330	2,415	933		
Gastro Intestinal				948	2,391	967		
Genito-Urinary				591	1,172	475		
Arthritic Rheumatism				1,429	3,778	1,408		
Other Diseases of Muscles, Bones, Joints				530	885	183		
Orthopedic and Neurologic				2,156	4,591	1,817		
Mental Retardation -								
Educable -								
Trainable -								
Severe -								
Economically, Educationally								
and Socially Deprived								

53,004
3,913
72

REHABILITATION DISTRICT 3 KEARNEY

Characteristics	Population Est. 1966	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS				Total
			No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity	
National	196,725,270	109,969,426	62,558,636	6,688,659	12,983,868	4,524,681	24,197,208
State	1,516,044	847,469	482,102	51,545	100,059	34,869	186,473
Region	263,857	147,496	83,907	8,971	17,415	6,069	32,455
County							
Visual Impairment				260	749	789	
Hearing Impairments				135	296	273	
Diabetes				144	400	249	
Heart Conditions				978	2,752	1,481	
Vascular				1,112	2,368	850	
Cancer							
Malignant Neoplasms				*	139	158	
Benign and Unspecified Neoplasms				90	174	79	
Mental and Nervous Conditions				637	1,219	443	
Respiratory				969	1,759	680	
Gastro Intestinal				691	1,742	704	
Genito-Urinary				431	853	346	
Arthritic Rheumatism				1,041	2,752	1,026	
Other Diseases of Muscles, Bones, Joints				386	644	134	
Orthopedic and Neurologic				1,570	3,344	1,323	
Mental Retardation -							
Educable -							38,602
Trainable-							2,850
Severe -							53
Economically, Educationally							
and Socially Deprived -							46,175

REHABILITATION DISTRICT 4
SCOTTSBLUFF

Characteristics	Population Est. 1966	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS				Total
			No Limita- tion In Activity	With Some Limitation In Activity	Limitations In Major Activity	Inability To Do Major Activity	
National	196,727,270	109,969,426	62,558,636	6,688,659	12,983,868	4,524,681	24,197,208
State	1,516,044	847,469	482,102	51,545	100,059	34,869	186,473
Region	119,785	66,960	38,092	4,073	7,906	2,755	14,734
County							
Visual Impairments				118	340	358	
Hearing Impairments				61	134	124	
Diabetes				65	182	113	
Heart Conditions				444	1,249	672	
Vascular				505	1,075	386	
Cancer							
Malignant Neoplasms				*	63	72	
Benign and Unspecified Neoplasms				41	79	36	
Mental and Nervous Conditions				289	553	201	
Respiratory				440	799	309	
Gastro Intestinal				314	791	320	
Genito-Urinary				196	387	157	
Arthritic Rheumatism				472	1,249	466	
Other Diseases of Muscles, Bones, Joints				175	293	61	
Orthopedic and Neurologic				713	1,518	601	
Mental Retardation -							
Educable -							17,525
Trainable-							1,294
Severe -							24
Economic, Educationally							
and Socially Deprived							20,962

REHABILITATION DISTRICT 5 NORFOLK

Characteristics	Population Est. 1966	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS					Total
			No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity		
National	196,725,270	109,969,426	62,588,636	6,688,659	12,983,868	4,525,868	24,197,208	
State	1,516,044	847,469	482,102	51,545	100,059	34,869	186,473	
Region	231,423	129,365	73,593	7,868	15,274	5,323	28,465	
County								
Visual Impairments				228	657	692		
Hearing Impairments				118	260	240		
Diabetes				126	351	218		
Heart Conditions				858	2,413	1,299		
Vascular				976	2,077	745		
Cancer								
Malignant Neoplasms				*	122	138		
Benign and Unspecified Neoplasms				79	153	69		
Mental and Nervous Conditions				599	1,069	389		
Respiratory				850	1,543	596		
Gastro Intestinal				606	1,527	617		
Genito-Urinary				378	748	303		
Arthritic Rheumatism				913	2,413	900		
Other Diseases of Muscles, Bones, Joints				338	565	117		
Orthopedic and Neurologic				1,377	2,933	1,160		
Mental Retardation - Educable -							33,857	
Trainable-							2,499	
Severe -							46	
Economically, Educationally							40,499	
and Socially Deprived -								

REGION 1
DISTRIBUTION OF HANDICAPPED
ACCORDING TO AGE AND SEX

Characteristics	Population Est. 1966	No Chronic Impairment		No Limitation In Activity		Limitation In Major Activity		Limitation Inability To Do Major Activity	
		Age and Sex		In Activity		In Activity		In Activity	
National	196,725,270	109,969,426	62,558,636	6,688,659	12,983,868	4,524,681			
State	1,516,044	847,469	482,102	51,545	100,059	34,869			
Rehab District	258,928	144,741	82,339	8,804	17,089	5,955			
Both Sexes:									
Under 17 years			91,919				1,011	735	184
17-44	"		91,143				2,825	4,101	547
45-64	"		52,562				3,101	6,097	1,472
65+	"		23,303				1,701	6,035	3,612
Male:									
Under 17 years			46,716				607	420	93
17-44	"		43,074				1,077	2,024	345
45-64	"		25,367				1,192	2,917	1,116
65+	"		10,423				542	2,658	2,272
Female:									
Under 17 years			42,205				452	316	90
17-44	"		48,005				1,776	2,112	192
45-64	"		27,070				1,922	3,194	379
65+	"		13,068				1,176	3,424	1,346

REGION 2
DISTRIBUTION OF HANDICAPPED
ACCORDING TO AGE AND SEX

Characteristics	Population Est. 1966	No Chronic Impairment	PERSONS WITH CHRONIC CONDITIONS			
			No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity
National	196,725,270	109,969,426	62,558,636	6,688,659	12,983,868	4,524,681
State	1,516,044	847,469	482,102	51,545	100,059	34,869
Rehab District	512,440	286,454	162,956	17,423	33,821	11,786
Both Sexes:						
Under 17 years			181,916	2,001	1,455	364
17-44	"	"	180,379	5,592	8,117	1,082
45-44	"	"	104,025	6,137	12,067	2,913
65+	"	"	46,119	3,367	11,945	7,148
Male:						
Under 17 years			92,454	1,202	832	185
17-44	"	"	85,247	2,131	4,007	682
45-64	"	"	50,204	2,360	5,773	2,209
65+	"	"	20,628	1,073	5,260	4,497
Female:						
Under 17 years			89,464	895	626	179
17-44	"	"	95,007	3,515	4,180	380
45,-64	"	"	53,573	3,804	6,322	750
65+	"	"	25,863	2,328	6,776	2,664

REGION 3
DISTRIBUTION OF HANDICAPPED
ACCORDING TO AGE AND SEX

Characteristics	Population Est. 1966	No Chronic Impairment	Age and Sex Distribution	PERSONS WITH CHRONIC CONDITIONS				
				No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity	
National	196,725,270	109,969,426		62,558,636	6,688,659	12,983,868	4,524,681	
State	1,516,044	847,469		482,102	51,545	100,059	34,869	
Rehab District								
Region	30,726	17,176		9,771	1,045	2,028	707	
Both Sexes:								
Under 17 years				10,908	120	87	22	
17-44	"			10,816	335	487	65	
45-64	"			6,237	368	723	175	
65+	"			2,765	202	716	429	
Male:								
Under 17 years				5,544	72	50	11	
17-44	"			5,111	128	240	41	
45-64	"			3,010	141	346	132	
65+	"			1,237	64	315	270	
Female:								
Under 17 years				5,364	54	38	11	
17-44	"			5,697	211	251	23	
45-64	"			3,212	228	379	45	
65+	"			1,551	140	406	160	

REGION 4
DISTRIBUTION OF HANDICAPPED
ACCORDING TO AGE AND SEX

Characteristics	Population Est. 1966	PERSONS WITH CHRONIC CONDITIONS				
		No Chronic Impairment	No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity	Inability To Do Major Activity
National	196,725,270	109,969,426	62,558,636	6,688,659	12,983,868	4,524,681
State	1,516,044	847,469	482,102	51,545	100,059	34,869
Rehab District Region	77,703	43,436	24,710	2,642	5,128	1,787
Both Sexes:						
Under 17 years			27,584	303	221	55
17-44	"		27,351	848	1,231	164
45-64	"		15,744	931	1,830	442
65+	"		6,993	510	1,811	1,083
Male:						
Under 17 years			14,019	182	126	28
17-44	"		12,926	323	608	103
45-64	"		7,613	358	875	335
65+	"		3,128	163	798	682
Female:						
Under 17 years			13,566	136	95	27
17-44	"		14,406	533	634	58
45-64	"		8,123	577	959	114
65+	"		3,922	353	1,028	404

REGION 5
DISTRIBUTION OF HANDICAPPED
ACCORDING TO AGE AND SEX

Characteristics	PERSONS WITH CHRONIC CONDITIONS					
	No Population Ext. 1966	No Chronic Impairment	Distribution Age and Sex	No Limita- tion In Activity	With Some Limitation In Activity	Limitation In Major Activity To Do Major Inability
National	196,725,270	109,969,426		62,558,636	6,688,659	12,983,868
State	1,516,044	847,469		482,102	51,545	100,059
Rehab District						
Region	89,937	50,275		28,600	3,058	5,936
						2,069
Both Sexes:						
Under 17 years						
17-44	"		31,928		351	255
45-64	"		31,658		981	1,425
65+	"		18,257		1,077	2,118
			8,094		591	2,096
						1,255
Male:						
Under 17 years						
17-44	"		16,226		211	146
45-64	"		14,961		374	703
65+	"		8,811		414	1,013
			3,620		188	923
						789
Female:						
Under 17 years						
17-44	"		15,702		157	110
45-64	"		16,674		617	734
65+	"		9,403		668	1,110
			4,539		409	1,189
						468

INTRODUCTION

Persons reading reports do so with differing degrees of expectation, interest and understanding. There are different levels of sophistication among readers. Some may be inclined to expect an exact accounting of every disease entity existent in a population. Others may only see in a report that which they want to see and grasp at straws to prove that their point of view is the correct one. Special interest groups will look for particular points to support their cause. Failing this or whatever else they desire to see, they may disregard everything else of value in the study or endeavor to label it a useless study.

With regard to the expectations and the special interests of the reader, it must be remembered that there are practical limitations and considerations regarding the extent of detailed coverage possible within a study based on a random sampling of a population. In order to utilize the findings to the best advantage, it is necessary to use broad, general classifications rather than specific items which could be infinite in number. The same limitation applies to areas of coverage in that figures reported for an entire state or large subdivision would tend to be more trustworthy than those given for a small area such as a small county.

Since the purpose of this study is to obtain information that will be of benefit to the entire rehabilitation program, it was designed to give a comprehensive overview rather than to single out specific disability groups for intensive study. The strengthening of the total program of rehabilitation will result in greater benefits to all special interest groups in the health field. This should have the effect of unifying and directing all of these efforts toward a common goal, that of providing adequate rehabilitation services to all eligible persons who request it.

The latter statement in the preceding paragraphs is worthy of some amplification, more particularly the last phrase "to all eligible persons who request it (rehabilitation services)." Many well-informed persons in affairs of state and even some associated with social welfare and related programs do not have a clear concept of the eligibility requirements that will enable a person to avail himself of the benefits of the rehabilitation act. There is a tendency to equate the rehabilitation program with those of welfare or to think in terms of the indigent person only.

Since its inception, the salient and distinguishing feature of the rehabilitation program was that its counseling, evaluation and training benefits were to be available to every person regardless of personal wealth. The emphasis has always been on investment in the individual in order that he may achieve maximum usefulness to himself and to society. The enactment of new legislation in 1965 and subsequent years has broadened the base of eligibility

considerably. It is necessary, therefore, to keep in mind that technically all handicapped persons referred to in this report are eligible for rehabilitation services; but many, because of age, ignorance of their rights or by personal election, may never avail themselves of their privileges.

It is hoped that this brief introduction may help orient the reader as to the scope and purpose of this study. It was felt that this clarification was necessary for greater receptivity to the subsequent report.

STATEWIDE SURVEY OF HANDICAPPED PERSONS

The reception of this portion of study has met with varying degrees of success, highly dependent on the motivation of the leadership within the Region. One additional person free to travel and freely work with Regional Chairmen would have been of considerable assistance in the accomplishment of this survey.

Under the leadership of Dr. Lois Schwab, Chairman of Region I, the survey of the Lincoln area was initiated. Four training sessions of the volunteers were held during a two week interval. Lincoln was divided into 136 "zones" averaging seven households each.

The volunteers in Lincoln were made up largely of volunteers from the Lincoln Hospital and Health Council, Jaycees, Mrs. Jaycees, Red Cross workers, and volunteer students from the University of Nebraska and Union College. Another group principally motivated by Mrs. Marti rounded out the group of volunteers. It was particularly gratifying and heartening to have the assistance of the executive group of the Division of Rehabilitation Services and the Services for the Visually Impaired. Not only did they participate by speaking to the volunteers, but actually participated in the survey itself.

An interesting sidelight is that in one training session involving approximately fifty persons, only three of the group knew anything about Vocational Rehabilitation prior to their attendance that evening. In a smaller group on a subsequent evening about eight persons had some knowledge of the function of the Rehabilitation program. It can be seen from this that there is a great deal of educational work to be done in order to acquaint people with the importance of rehabilitation work and its benefits to society.

The Omaha Jaycees performed a similar service in Omaha. Other civic clubs have volunteered their services which helped to round out the group that surveyed Omaha.

The Omaha survey was very important since the problems of the handicapped are of a different nature than the balance of the State. The ethnic structure, economic problems, cultural and educational deprivation are some of the chief differences that were considered.

Throughout the State, enough data was gathered that a good cross-section of the handicapped population was assessed. The incidence of handicapping conditions, the relationship of age, rural and urban comparisons was felt to be adequately drawn.

The emphasis in the Nebraska Statewide Plan has been on a continuously unfolding procedure which will be flexible enough, when once established, to allow for changes in emphasis as each goal approaches reality. Fulfillment of specific goals tend to change the nature of problems and,

in fact, to create new ones in the solution of the old. Planning needs to be reality based in order to be practical. Reality changes with time and hence what was the real problem in one period of time, ceases to be so a year later. Other problems, seemingly refractive to change, increase with time and have to be subject to continuous analysis, probing to discover causes and reviewing past performances to identify possible "hang-ups".

There is a disadvantage in this process in that it is not always apparent to the observer that progress is being made. Much of the data gathered is stored in the computer and on computer software, adding to the store of knowledge that is necessary to formulate a sound foundation for this type of planning. The dollar and cents cost for such planning or change of direction of plans can usually be incorporated in the program allowing for good budget estimates based on past experience as well as the future indices of rising costs. If there is an appreciable acceleration towards the achievement of one goal or a need to level off it can be accomplished. Once a planning program is fully initiated and various standards for operation are programmed, various types of situations may be posited and simulated to provide information for future budgets and comparisons of various suggested approaches to solutions to problems.

The programming for the expansion of the rehabilitation services in Nebraska should be based on fundamental data which will be found to be the most meaningful relative to measuring past growth and achievement, as well as basic to predicting future needs. The time cycle under consideration felt to be adequate enough with respect to length to provide sufficient depth of data for basic calculations and yet not be too broad to be insensitive to current trends to accomplish the above goals will be five(5) years. The intensity and rapidity of fluctuation in trends will govern the size of the basic time increments or intervals within the five(5) year period.

Careful examination of the data being processed is necessary in order that maximum efficiency in planning be maintained. This involves the screening out of extraneous matter, avoidance of the possibility of duplication and preventing the introduction of spurious and irrelevant material. Only data meaningful to the planning process is retained.

On the agency level, with proper processing information, realistic budgets can be proposed incorporating the features of orderly growth, anticipating not only financial needs, but the personnel necessary for the accomplishment of the program. Through the utilization of simulation procedures various elements of changes can be introduced into the program in order to ascertain their effect on the total program. It will be possible to estimate the impact of already instituted programs on the future overall agency operation as well as the effect on the state economy as a whole.

The simulation feature lends itself readily to improved fiscal and operational control, particularly if data is fed into the computer on a quarterly basis. With the introduction of current quarterly data, projections for the year can be forecast. Early trends can be assessed

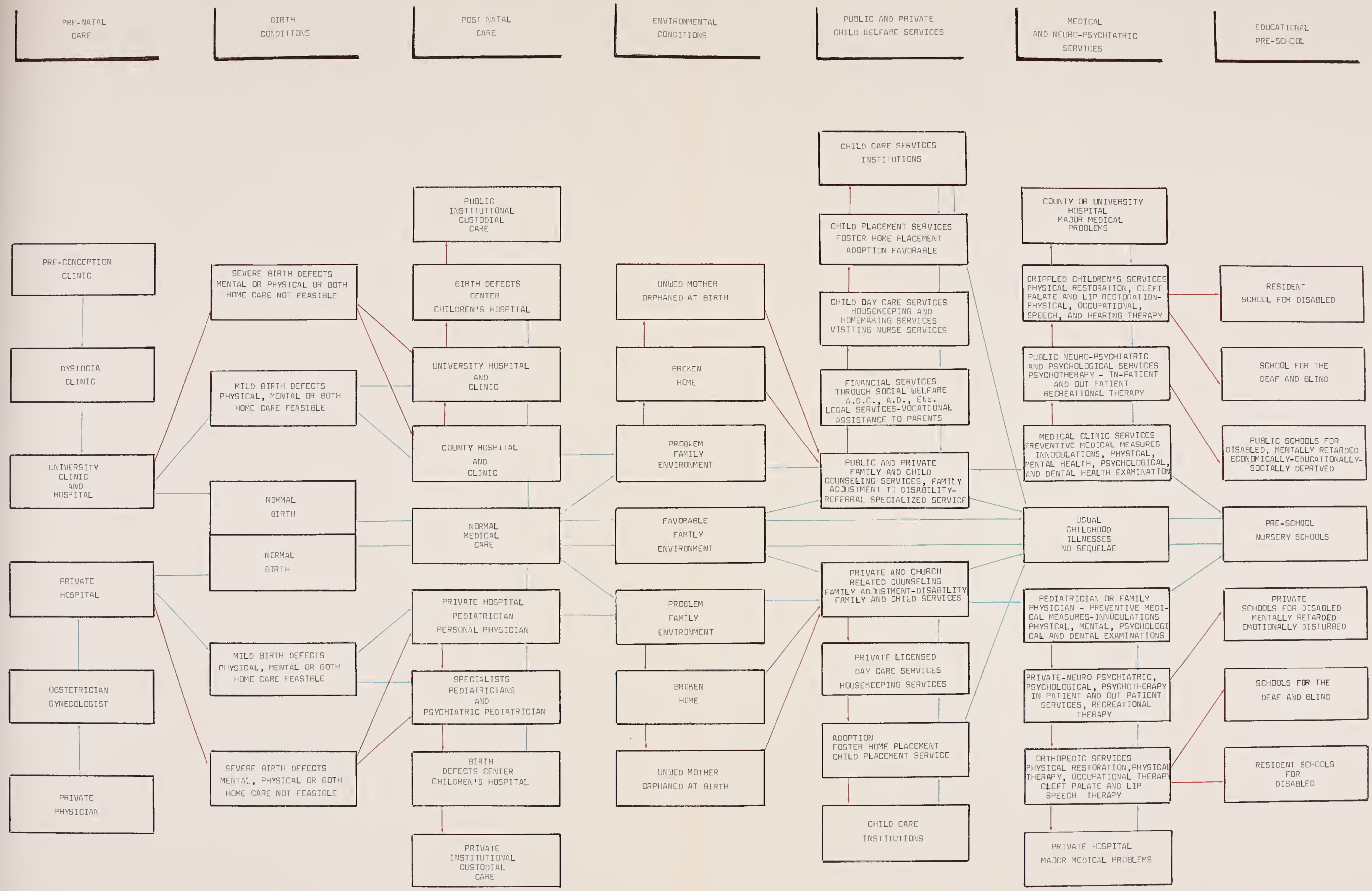
in advance, suggesting areas of strengths and weaknesses in the present operation that can be augmented or modified if so needed.

Considering the state operation from the standpoint of the establishment of new facilities, coordination of other services with that of the rehabilitation effort and the better utilization of already established resources to that end is discussed in the next section.

PRE-SCHOOL CHART

PUBLIC CARE

PRIVATE CARE



Population Densities and Topography

The population distribution of the State of Nebraska varies widely from less than one person per square mile (.7883 lowest) in the western part of the state to 1200 persons per square mile in Douglas County in the easternmost section. Nebraska ranks fifteenth in area when compared with other states. One large county is greater in area than the entire state of Connecticut, yet in population has only 1.3 persons per square mile. Connecticut, according to the 1960 census, had a concentration of 517.5 persons per square mile. Six counties are individually larger in size than Rhode Island, but only one of these counties has a population density of twelve persons per square mile.

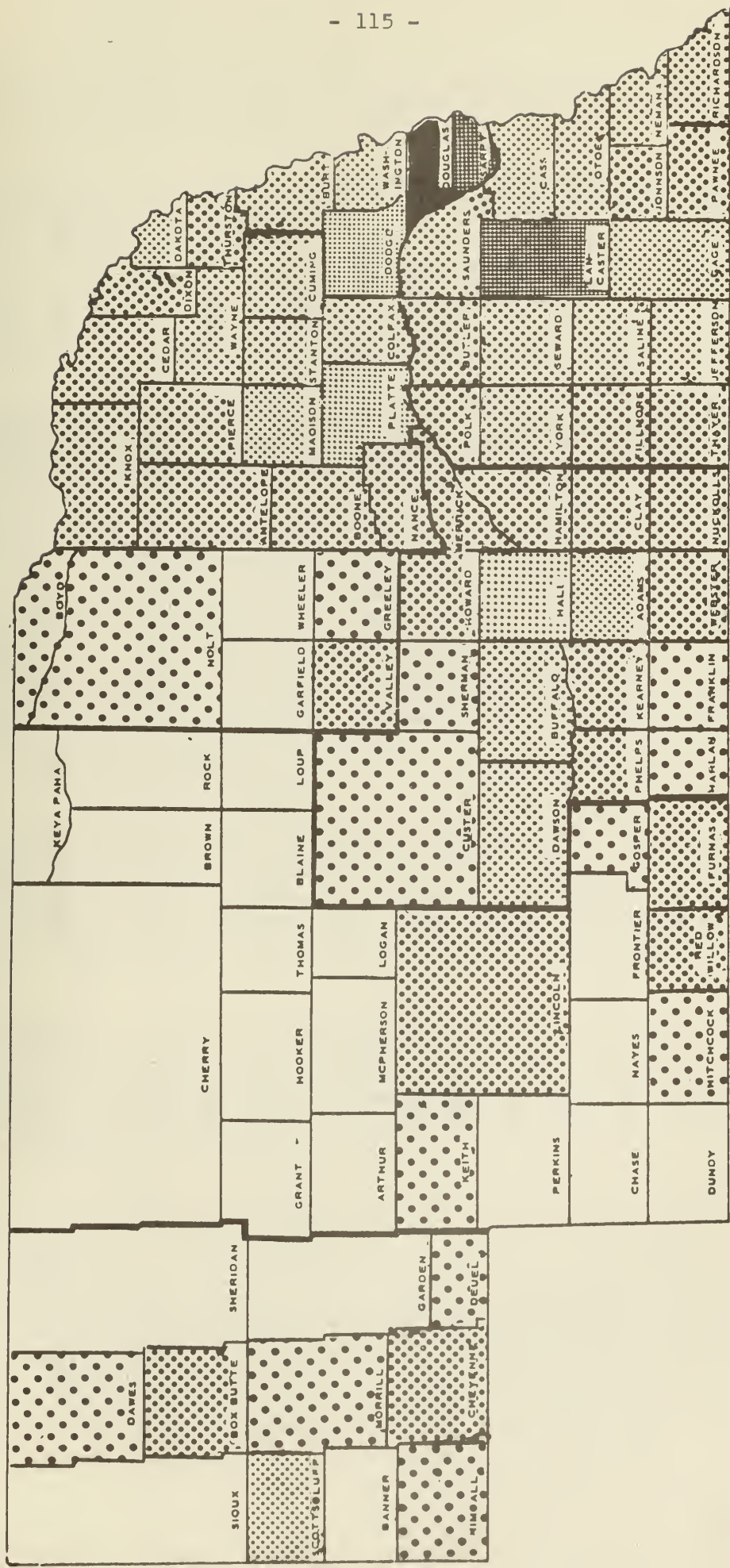
The population concentration is largely in the eastern section of the state and to a lesser degree along the Platte River which flows from the west to the east. Other smaller population concentrations follow the Republican River Valley in the south, the Elkhorn and Niobrara Rivers in the northeast section.

The topography of the eastern section is largely that of rolling hills. The soil composition is a brownish, sandy clay loam (loess) combined with fertile soil in the river valleys that have, in the past, supported many small farms. The sandhills in the northeast central section and the western panhandle are now mainly composed of large ranching combines, hence the smaller population ratio to area.

Table I, P. 116 lists the fifteen regions, identifying each with the largest city within the region. The population estimates were those calculated by the Bureau of Business Research of the University of Nebraska from data furnished by state and county governmental agencies. The population ranges from 15,977 in Region 15 to 514,308 in Region 2. It will be noted that the population densities, for both regions are also the lowest and highest, 1.8 and 187.0 respectively; roughly, the population density of Region 2 is 100 times that of Region 15 and hence both present totally different problems in the terms of rehabilitation.

The shortage of professional personnel and treatment facilities as well as the lack of employment opportunities for severely handicapped persons are the challenging problems of the sparsely populated areas. Conversely, in the densely populated areas, the plight of the handicapped person can be just as easily overlooked or neglected in spite of the plenitude of services, ostensibly available to him. The problem of being unable to provide services because of inadequate funding or lack of personnel can be as frustrating to an agency as the barriers created by open country. Problems of service and funding will be considered in other sections of this report.

The population per household is given in column 4 of Table 1, p. 116. The range in size of household is 2.9 to 3.5 persons throughout the

DENSITY OF POPULATION PER COUNTY

POPULATION CHARACTERISTICS

<u>Region Number and Largest City</u>	<u>Population of Region 1967 Est.</u>	<u>Population Density Per Sq. Mile</u>	<u>Average Size of Household</u>	<u>Percent Handicapping Conditions</u>	<u>Area in Square Miles</u>
1. Lincoln	259,780	54.4	3.2	11.87	4,778
2. Omaha	514,308	187.0	3.3	11.04	2,750
3. Alliance	30,914	4.4	3.2	9.95	6,984
4. Beatrice	79,403	21.1	2.9	8.15	3,739
5. Fremont	89,758	34.3	3.5	9.9	2,615
6. Grand Island	85,723	17.2	3.0	10.28	4,970
7. Hastings	65,972	19.5	2.9	8.92	3,376
8. Kearney	77,303	11.4	3.0	11.89	6,785
9. McCook	32,762	9.0	3.3	10.77	3,627
10. Norfolk	60,064	19.3	3.5	9.69	3,112
11. North Platte	56,748	5.0	3.3	10.41	11,359
12. O'Neill	30,561	7.5	3.4	9.13	4,051
13. Scotts Bluff	70,969	10.0	3.2	10.19	7,126
14. So. Sioux City	51,412	22.3	3.5	8.69	2,309
15. Valentine	<u>15,977</u>	<u>1.8</u>	<u>3.1</u>	<u>8.98</u>	<u>8,981</u>
Total	1,521,654	19.9	3.2	10.52	76,612

15 regions. The state average is 3.2 which seems to follow the steady trend towards smaller households that has been noted nationally in the past seventy years.

The percent of handicapping conditions varies from region to region. The range is from 8.15% to 11.89% with a state average of 10.52. (Obtained from Statewide Survey)

Statewide Survey

One of the purposes of the Nebraska study was to determine the number and kind of handicapping conditions existing across the state. A number of reasons were advanced initially to justify the necessity of this procedure. One very important consideration was the urgent need to provide tangible evidence to the Governor, Legislators, and the people of Nebraska of the magnitude of the problems presented by chronic disabling conditions and disease.

In order to accomplish this objective the state was divided into fifteen regions. The rationale behind the regional partitioning was outlined in the twelve-month report together with a report on the validation of the survey instrument. A systematic sample was obtained by selecting every fortieth household in the eastern section of the state and every twentieth household in the western half. City directories, rural listings obtained from county assessors, and listings compiled by commercial listing agencies were the sampling sources. Volunteers in the fifteen regions were trained in the use of the questionnaire form and assigned, on the average, seven households to interview.

It was apparent that complete coverage of the state would be impossible even though a goodly number of volunteers were obtained in practically every region. Many counties, however, were so well covered that it was possible with extra follow-up emphasis, particularly in the metropolitan areas, to obtain a good sampling representation of every area of the state.

Table II, p. 118, gives additional regional information based on the Statewide Census of handicapping conditions. Column I lists the estimated number of persons with chronic disabling conditions, in each region. The successive columns tabulate the degree and type of limitations as expressed by each individual without regard for specific diagnostic classification.

Persons listed in columns 2 and 3 are those that have a chronic condition but do not feel that they are limited appreciably in their major activity by their disability. Those persons listed in column 2 may feel some discomfort and inconvenience but have been able to compensate or adjust to their problem very adequately. Column 3 lists those persons who have no problems as long as they take their medication regularly or make use of compensating devices such as braces or prosthetic appliances. These persons may be diabetic, controlled epileptics, have an allergic condition, or utilize some prosthetic device to compensate for their limitations.

Table II

LIMITATIONS OF PERSONS CHRONICALLY DISABLED

Region Number and Largest City	Estimated Number Handicapped	No Limitation			Psychological-Sensory			Physically Limited		
		No Appreciable Limitation	Compensation by Medical Prostheses	Academic Psychosocial Physical	Visual, Speech & Hearing	Non- Apparent	Apparent	Profound		
		1	2	3	4	5	6	7	8	
1. Lincoln	30,846	1,505	4,994	2,734	3,772	10,188	3,398	4,240		
2. Omaha	56,796	2,554	8,817	5,424	5,240	19,524	6,374	7,597		
3. Alliance	3,078	162	432	324	252	1,170	306	432		
4. Beatrice	6,471	385	616	616	693	2,541	770	847		
5. Fremont	8,874	840	1,200	540	720	3,778	1,020	780		
6. Grand Island	8,814	140	1,260	140	980	3,779	1,400	1,120		
7. Hastings	5,891	285	624	568	568	2,437	738	682		
8. Kearney	9,185	104	1,147	312	1,043	3,755	1,670	1,146		
9. McCook	3,529	167	427	426	214	1,445	358	501		
10. Norfolk	5,817	648	647	448	498	2,439	598	549		
11. North Platte	5,907	264	726	627	462	2,343	693	792		
12. O'Neill	2,787	266	343	190	247	1,181	323	228		
13. Scottsbluff	7,332	416	1,040	884	468	2,860	572	1,092		
14. So. Sioux City	4,432	391	459	413	460	1,836	506	368		
15. Valentine	1,426	62	279	62	186	496	217	124		
Totals	161,185	8,489	23,011	13,708	16,803	59,772	18,943	20,498		
Percentages	10.52%	5.27%	14.28%	8.51%	10.42%	37.08%	11.47%	12.72%		

Those tabulated in column 4 are those persons who feel that their chief limitations are largely due to a poor educational background, psycho-social difficulties or other psychological reasons. All conditions are severe enough to be considered handicapping and rendering them eligible for rehabilitation services.

Listed in the 5th column are those persons who have definite sensory limitations which are not 100% correctible by means of hearing aids or glasses. Speech problems resulting from hearing deficiencies in early childhood as well as those persons afflicted by hare lip and cleft palate are also included here.

The last three columns list those persons having definite physical limitations that affect the type of employment they can accept. Column 6 lists individuals who have chronic disorders that may not be readily apparent to their colleagues but may be seriously limiting. Such conditions include cardio-vascular disorders, malignancies, respiratory problems, etc. Tabulated in column 7 are individuals with definitely apparent physical limitations. These disabilities may be neurologic disorders, such as Parkinson's disease and multiple sclerosis, or orthopedic impairments and other disabilities apparent to the casual observer.

Table II, p. 120, presents the accumulated statewide data on chronic disability from another point of view. Column I tabulates the number of pre-school children (0-4 years) with handicapping conditions. It is very probable that a number of the handicapped children may not be as readily recognized or accounted for in this age group for various good reasons. Many parents are hesitant to face realities and acknowledge the possibility that their child may be physically or mentally handicapped. Their reactions to the child's disability take many forms of adjustment, from total rejection of the problem to total rejection of the child. Unless the parent makes a positive and adequate adaptation to the child's problem at this time, the long term ability to adjust vocationally, emotionally, and physically will be profoundly impaired in the future.

It is mandatory that those persons involved in the vocational rehabilitation of the adult take an active participation in the introduction of preventive rehabilitation measures with respect to the pre-school child. Early recognition and identification of mental retardation, neurological disorders and other physical disabilities must be made, particularly those chronic disorders whose symptoms are not so readily apparent to the untrained person. It is therefore recommended that:

1. Lines of communication be established with those public and private organizations that concentrate on special disability groups - encouraging not only research specific to the disability itself but to direct attention to the psychological aspects concomitant with the condition that may have far-reaching implications for the eventual rehabilitation of the individual as an adult.

Table III

AGE RANGES OF PERSONS WITH CHRONIC DISABILITIES

Region Number and Largest City		0-4	5-15	16-25	26-35	36-45	46-55	56-65	66-75	75-99
1.	Lincoln	848	6,414	2,169	2,358	2,452	4,339	3,207	4,810	4,244
2.	Omaha	1,626	11,925	4,878	3,659	4,743	8,266	6,098	8,944	6,640
3.	Alliance	107	413	269	197	143	395	485	485	575
4.	Beatrice	77	1,079	385	308	462	616	1,310	1,310	925
5.	Fremont	299	1,677	539	958	479	1,078	1,378	1,198	1,258
6.	Grand Island	139	1,538	279	279	839	839	1,538	1,957	1,398
7.	Hastings	56	961	282	226	509	509	1,244	1,131	961
8.	Kearney	417	1,462	208	208	731	1,044	1,462	1,566	2,089
9.	McCook	71	473	284	236	236	355	686	568	615
10.	Norfolk	198	1,044	447	745	397	596	994	745	646
11.	North Platte	198	825	462	363	330	693	1,023	891	1,122
12.	O'Neill	76	516	210	305	191	286	497	401	305
13.	Scottsbluff	156	936	676	520	416	832	1,300	1,248	1,248
14.	So. Sioux City	160	801	412	458	274	412	733	687	481
15.	Valentine	92	216	92	30	30	247	154	216	339
Totals		4,520	30,280	11,592	10,850	12,232	20,507	22,109	26,157	22,846
Percentages		2.8%	18.79%	7.20%	6.73%	7.59%	12.73%	13.73%	16.24%	14.18%

2. To foster intensive longitudinal research studies that will parallel the physical, social and psychological growth of the individual in the process of maturation in order to ascertain the long range effects of home and outside (school, activities, etc.) environment on the individual's eventual success or failure.

3. To conduct an active public relations program to impress on parents the importance of early recognition, preventive aspects as well as facilities, professional help and other specific information available to them, pertinent to the disability and best possible adjustment.

It will be noted in Table III, page 120, that the number of persons recorded in the age ranges of 5 to 15 (column 2) reflects a considerably greater number of persons with chronic disorders. It is at this period of the child's life that he, as well as the parents, is confronted with some of the sobering realities of life. In the stress of academic and physical competition some of the basic problems that may not have been apparent or ignored in early childhood will make themselves manifest. If parents, by means of denial, have refused to recognize their child's deficiency, they will undoubtedly have to do so now. This confrontation may be part of the reason that the figure of 30,280 disabilities may seem to be disproportionately larger by comparison with the below 5 age range. It will also be noted that the age range coverage applies to a 15-year period.

The faulty as well as positive modes of adjustments learned during the first five years of life will manifest themselves during this period, too. The ability or inability to socialize, to retreat or face reality, to finish jobs begun or to procrastinate, and other adjustments, will become apparent. At this stage of life, particularly during the first five(5) or six(6) grades, vocabulary enrichment, the ability to read or spell, and the foundation in mathematics are laid. If these areas of positive adjustment and academic growth are neglected, the person, in addition to his handicap, will have almost insuperable obstacles to overcome later in life. The areas of faulty adjustment can cause innumerable conflicts concerning right and wrong, lack of follow-through, generalized apathy and other signs of lack of maturity. Past experiences with the educationally deprived and others who, for some reason or other, never applied themselves diligently to academic pursuits in earlier years, have shown that it is almost impossible to make up for these deficits in later years. The ability to socialize, cooperate and work with others are also extremely important lessons to learn during the first five(5) or six(6) grades.

From this standpoint then, it is clearly the business of rehabilitation services to keep in close communication with the school-age children and any organizations working closely with them. Since this is a large group, 35,988 persons with chronic disability, it should be at once of great concern and merit special attention in that it represents one of the larger sources of future rehabilitation clients. The following recommendations are presented for this group in addition to those proposed for the pre-school children:

1. Working agreements with those high schools having a sufficient number of handicapped students warranting a special education teacher on the staff in the form of third party agreement

(a) Counselors employed for this purpose should possess an educational background equivalent to that of requirements of the general rehabilitation services.

(b) The counselor should be responsible to the District Supervisor of his area, and his work and caseload regularly reviewed as a check on efficient operation. Since the financing for the programs comes largely from the rehabilitation budget, this should be an accepted procedure.

(c) The professional staff of the Division of Rehabilitation Services should enjoy the same status in the education system as accorded other professional personnel. Within the province of his expertise, the counselor should be consulted with regard to the vocational training of every handicapped child in the school. He should work closely with all specialists provided by the school (speech and hearing, school psychologist, and other related personnel) in order to effectively coordinate their efforts on behalf of the handicapped child. He should be alert to the more serious manifestations of mental problems or physical disorders so that proper specialists can be obtained for the most serious problems.

(d) Services needed for the handicapped child, over and beyond those provided by the school should be paid for out of the matching third party funds to insure that all necessary services are obtained.

(e) The counselor's caseload would be composed of every child who applies for preventive rehabilitation services through the parents' initiative, providing he meets the qualifications for eligibility as provided by the Rehabilitation Act. The State Plan for the Division of Rehabilitation services should be amended accordingly.

(f) In the beginning it would be advisable to limit services to those students of high school age only and extend the services of the organization to the lower grades as funds and acquisition of qualified personnel permit.

(g) Performance of the counselor would be judged on the basis of his ability to coordinate activities of the available professional personnel. To fulfill the needs of the client, the effectiveness will be demonstrated by future successful rehabilitations obtained by cooperating state counselors. The counselor must be able to ultimately extend and expand rehabilitation services to all handicapped persons of the elementary and secondary level.

Before extending this discussion to the person commonly considered to be of rehabilitation age, mention should be made of a particularly large sector of the population. Columns eight(8) and nine(9) of Table III, page 120, list those persons who are of retirement age (over 65). There are approximately 49,000 persons in this group and they constitute 30.42% of the chronically disabled population. This group will tend to grow somewhat larger every year due to the utilization of more effective medications and more congenial living conditions. The problems experienced by this group should be of interest to the individuals involved in rehabilitation. An attempt should be made to tap the hidden resources of wisdom and experience of this group. These people, in many areas of the country, have been utilized as foster grandparents and have been paid according to the minimum hourly wage law. They have had their own lives enriched as well as provided underprivileged and mentally retarded children with the benefit of their wisdom and experience and capacity to love. This group of people constitute a resource that the counselor in the school or institution could summon in the form of an auxiliary force to augment his need for interested people to aid him.

From the standpoint of service to older age groups, there is a distinct need to assist many of them to financial independence and give their lives a purpose. The Foster-Grandparent Program should be thoroughly investigated as an adjunct program in preventive rehabilitation, providing a dual purpose in assisting the older age group and at the same time contributing to the education, training, and socialization of underprivileged and mentally retarded children.

The Foster-Grandparent Program in other states has been found to provide a reciprocal value to the young and old alike. Each have provided the other with mutual respect and a feeling of self-worth. It has provided to both age groups a sense of being needed. It has contributed to persons above retirement age by adding to their income, as well as fulfilling their need to be useful members of society.

Table IV
Age Vs. Extent of Limitation
Statewide Census Findings
N=161,158

Age	No Appreciable Limitation	Compensated Medically Physically	Academic Psycho-Social Psychological	Visual Speech Hearing	Definite Major Limitation		
	(1)	(2)	(3)	(4)	Hidden (5)	Apparent (6)	Profound (7) Total
0-4	568	957	379	766	1,398	-	460 4,528
5-15	2,114	5,675	8,726	5,497	5,391	1,499	1,384 30,286
Over 15 School Age Total	<u>611</u> 3,293	<u>646</u> 7,278	<u>2,954</u> 12,059	<u>1</u> 6,264	<u>1,354</u> 8,143	<u>2</u> 1,501	<u>134</u> 1,978 <u>5,702</u> 40,516
16-25	136	361	681	135	2,769	251	1,565 5,898
26-35	895	2,281	309	483	4,668	763	1,460 10,859
36-45	460	1,827	262	2,286	4,160	975	2,269 12,239
46-55	1,311	3,729	127	1,685	8,193	2,649	2,820 20,514
56-65	<u>1,030</u>	<u>2,181</u>	<u>134</u>	<u>1,258</u>	<u>11,966</u>	<u>2,644</u>	<u>2,901</u> <u>22,114</u>
Productive Age Range - Total	3,832	10,379	1,513	5,847	31,756	7,282	11,015 71,624
66-75	1,102	3,612	134	1,569	11,574	5,197	2,978 26,166
76-99	<u>254</u>	<u>1,735</u>	-	<u>3,115</u>	<u>8,285</u>	<u>4,948</u>	<u>4,515</u> <u>22,852</u>
Retirement Age Range - Total	1,356	5,347	134	4,684	19,859	10,145	7,493 49,018

Of particular interest in Table IV, page 124, which combines the degree of limitation, as reported by the chronically disabled, with their age ranges. Arranging the above distributions in this fashion makes it possible to screen out those persons who will be less apt to benefit from the rehabilitation process by virtue of age, severity of disability or because of evident self-sufficiency. A more realistic approach to the problem can be arrived at by means of inspection and the process of elimination. The persons enumerated in the top three rows and bottom two rows can be eliminated on the basis of age. There are 34,814 persons in the pre-school and school age range and 49,018 persons of retirement age. Deducting the sum of these two groups (83,832 persons) from the total of 161,158 chronically disabled persons leaves a balance of 77,326 persons eligible for rehabilitation services in the productive age range of 16 to 65.

Directing attention to the columns, the possibility of further reducing the above figure of 77,326 becomes apparent. The persons listed in the first two columns are those who have indicated that in spite of the fact that they do have a chronic disability, they are not limited with respect to performing their major activities. The sum of the first two columns in the productive age range is 15,468 and subtracting this figure from the above remainder reduces the number of potential rehabilitation clients to 61,858. This figure can be reduced still further by the 11,149 profoundly handicapped persons tabulated in column seven(7). This brings the figure to 50,709 persons who could utilize rehabilitation services to the greatest advantage. The overwhelming majority of this group are not presently being served by either of the state rehabilitation services.

Table V. MAJOR DISABILITY VS. EXTENT OF LIMITATION - STATEWIDE CENSUS FINDINGS

Disability	No Appreciable Limitation (1)	Compensated Medically Physically (2)	Academic Psycho-Social (3)	Visual Speech Hearing (4)	Definite Hidden (5)	Major Apparent Limitation (6)	Profound (7)	Total (8)
Blind	533	980	230	4,879	152	838	594	8,204
Other Visual Imp.	779	460	-	2,123	134	136	714	4,343
Deaf	-	-	-	1,023	-	-	-	1,023
Other Hear. Imp.	127	842	134	2,979	460	-	-	4,541
Orthopedic Imp.	1,869	2,333	936	1,468	14,327	10,962	4,497	36,394
Amputations	-	230	-	-	279	1,060	-	1,566
NeuroPsychiatric	230	816	775	-	1,726	134	-	5,577
Alcoholism & Charac.	152	749	4,842	-	101	-	1,511	7,355
Mental Retardation	326	545	5,352	460	466	-	1,641	8,609
Malignant Neoplasms	101	127	-	-	882	-	322	1,432
Hay Fever-Asthma	635	3,176	127	-	3,618	520	362	8,457
Other Allergies	338	1,965	-	-	2,464	-	-	4,767
Diabetes Mellitus	611	4,609	-	-	3,976	-	593	9,790
Other End. Dis.	-	230	357	-	398	127	-	1,111
Blood Disorders	-	230	-	-	1,071	-	-	1,301
Epilepsy	-	382	-	230	906	127	152	1,796
Other Neur.	230	-	-	271	1,068	382	218	2,166
Heart Disease	918	1,191	230	646	17,436	4,132	5,207	29,757
Vascular	230	1,529	134	-	4,060	-	230	6,202
Tuberculosis	-	-	-	-	230	-	378	606
Emphysema	-	127	-	-	2,328	-	276	2,733
Other Respiratory	628	186	-	-	1,239	-	23	2,075
Digestive System	230	418	-	230	1,465	-	491	2,634
Genito-Urinary Sys.	260	-	-	-	136	-	414	610
Speech	152	1,226	439	2,487	150	-	-	4,453
Disorders of Skin	-	230	-	-	365	-	-	595
Other N.E.C.	-	425	-	-	134	-	-	559
Social & Ed. Dep.	136	-	152	-	134	506	952	1,673
Totals	8,485	23,006	13,708	16,796	59,764	18,934	20,493	161,167

DIAGNOSTIC CLASSIFICATION

The original list of disorders as literally reported on the survey form were reduced to 83 diagnostic classifications by conversion to the VRA Code. The VRA Code is a systematic means of numerically classifying all diagnostic categories regularly serviced by the Vocational Rehabilitation Services and universally used by the state offices as well as the federal office for identification purposes.

The Code consists of three identifying numbers. The first number refers to the broadest classification and identifies the category of the disorder. For example, 1--refers to the blind and visually impaired. The number 2 with dashes behind it (2--) represents all hearing impairments. Orthopedic problems are designated by the prefix of 3--. The second number of the series represents the degree of impairment and the third number the specific diagnostic category. For example: If the number 300 was indicated, the first number "3" would identify this as an orthopedic impairment. An "0" or "1" following the "3" would identify that impairment as an involvement of three or more limbs. The final "0" is the code for cerebral palsy within the orthopedic category. The Code number 320 would also indicate a cerebral palsy condition, but the second number "2" in this case is indicative of an involvement of an upper and lower limb (including side) due to cerebral palsy.

Tables V and VI, pp. 126 and 128, relate 29 diagnostic classifications with the extent of limitation and age range respectively. Subsequent Tables utilizing diagnostic classifications will be condensed to 18 broad categories according to the first number of the VRA Code given above and will be identified by that number followed by one or two dashes in accordance to the policy of using broader or more general classification as outlined in the introduction.

Tables V and VI give some idea as to the number in many specific categories as extrapolated from the census figures. Although figures obtained by this method should be interpreted with caution, it has been noted that many of these figures seem to be in rather close agreement with those obtained from other sources, particularly with those obtained on the National Health Survey. It is not expected that they will totally agree with everyone's concept as to what the figures should be or with other studies in their entirety, since every study has their own particular strength and weaknesses as well as areas of emphasis. There are also variations from state to state that have to be considered. A researcher can only report on the figures he obtains, no more and no less.

The figures reported on all disability Tables are based on the individual's stated primary disability, unless other wise noted in the text or table. The primary disability is the disabling factor that presents the greatest problem to the person. In some

MAJOR DISABILITY VS. AGE RANGE - STATEWIDE CENSUS FINDINGS

Disability	0-4	5-15	16-25	26-35	36-45	46-55	56-65	66-75	76-99
Blind	151	611	135	437	839	1,162	1,124	1,274	2,457
Other Visual Imp.	229	521	259	277	302	459	592	647	1,045
Deaf	-	181	-	229	459	-	-	-	151
Other Hearing Imp.	135	1,118	133	229	151	306	148	495	1,615
Orthopedic Imp.	1,340	4,267	2,119	2,313	4,039	7,142	5,012	5,054	5,054
Amputations	-	-	229	381	-	355	151	262	186
Neuro-Psychiatric	-	971	229	1,173	229	1,390	394	1,185	377
Alcoholism & Charac.	-	3,919	1,950	229	229	330	317	-	-
Mental Retardation	229	5,158	2,073	356	630	356	-	-	-
Malignant Neoplasms	-	-	-	-	381	592	135	321	-
Hay Fever-Asthma	703	4,022	1,310	533	229	459	151	1,045	-
Other Allergies	754	1,075	643	533	562	854	344	-	-
Diabetes Mellitus	135	823	-	2,196	912	1,457	1,640	2,443	181
Other End. Dis.	-	595	135	126	-	-	-	-	253
Blood Disorders	229	229	229	-	-	229	-	151	229
Epilepsy	-	1,016	287	229	135	126	-	-	-
Other Neur.	-	416	229	151	447	135	519	135	151
Heart Disease	252	480	252	933	947	2,853	6,739	9,270	8,018
Vascular	-	-	-	126	-	781	2,431	1,833	1,027
Tuberculosis	-	-	-	-	-	-	607	-	-
Emphysema	-	-	-	-	151	126	864	583	1,007
Other Respiratory	-	686	229	-	377	261	-	203	313
Digestive System	-	229	133	126	317	458	637	610	314
Genito-Urinary	-	133	135	135	-	-	151	126	126
Speech	360	3,584	126	-	377	-	-	-	-
Disease of Skin	-	229	229	-	135	-	-	-	-
Other N.E.C.	-	-	-	-	-	425	133	-	-
Social & Ed. Dep.	-	-	517	126	365	229	-	505	133
Totals	4,517	30,263	11,581	10,838	12,213	20,485	22,089	26,142	22,837

instances it was difficult to establish the degree of impairment particularly when evaluating visual problems. It was known, however, that the amount of impairment experienced was of such a nature that it did lead to an inadequate vocational adjustment.

In some cases the primary disability so over shadowed other disorders experienced by the person identified in the census that secondary problems were not always given. The intent in this survey was to prevent duplication by making it impossible for the same individual to be counted several times because of multiple disabilities. This makes it possible to present the problems of disability more realistically for planning purposes.

A review of Tables V and VI and comparing the results obtained with other studies would indicate that the findings were, as a general rule, conservative rather than over-stated. It is noted, for example, that the greatest number of mental retardates were identified during the school years (Table VI, p. 178) as one progresses up the age range, it is noted that very few are identified after ages 16 - 25 and none are reported above age 55. This does not mean there are no retardates above 55 or less in number above age 25, but that they are gradually absorbed in the working force, are institutionalized, or become unpaid family workers.

On the other end of the scale, certain disorders do not manifest themselves until later on in the person's life. Diabetes, cardio-vascular disorders, respiratory problems increase in severity or become more apparent with time. In certain disorders the onset is insidious and does not manifest itself until senescence or when circumstances become favorable to its emergence.

One of the methods that is often used to check a sample is to compare certain characteristics of the sample against the total population. If these compare favorably with one another, more confidence can be given to the sample findings. Table VII, on the next page, compares the sample age ranges with the figures obtained nationally and reported by the U.S. Book of Facts, Statistics and Information. It will be noted that the class intervals as reported in the sample and given by the National source are not entirely identical but if these differences could be reconciled the class intervals would be more nearly alike. For example, the second class interval in the sample is 3.7% larger than that shown in the national population. However, it will be noted that an extra year is included in the Nebraska sample (5 - 15 years) as opposed to 5 - 14 years in the National population. The subsequent class intervals are an even 10 years each and compare very favorably as to percentages of people in each of the intervals.

Table VIII, p. 131, compares the results that were obtained in the Nebraska Study with those of the National Health Survey. There may be some error in grouping, due to some difference in definition or classification. It must be noted that the National Health Survey allows for duplication in all areas and the list is made up of all levels of disabilities rather than limiting selection to the primary disability. A comparison of the figures obtained on both

COMPARISON OF PERCENTAGE OF PERSONS IN AGE RANGES OBTAINED FROM SAMPLEAND THOSE OF THE NATIONAL POPULATION

<u>Nebraska Age Range</u>	<u>State Sample Population</u>	<u>Sample Percentages</u>	<u>National Percentages</u>	<u>National* Population</u>	<u>National Age Class Interval</u>
0-4	118,417	7.8%	10.1%	19,851	Under 5
5-15	367,253	24.2%	20.5%	40,208	5-14
16-25	219,781	14.5%	16.0%	31,362	15-24
26-35	162,094	10.7%	11.4%	22,324	25-34
36-45	182,796	12.0%	12.3%	24,097	35-44
46-55	168,070	11.1%	11.4%	22,298	45-54
56-65	132,054	8.7%	8.8%	17,260	55-64
Over 65	<u>169,913</u>	<u>11.2%</u>	<u>9.4%</u>	18,456	65 and over
	1,520,378	100.2%	99.9%		

*National figures in Thousands 1966

TABLE VIII
Distribution of Disabilities
According To Degree Of Handicapping
Condition

<u>Disability</u>	<u>V.R.A. Code</u>	<u>Primary</u>	<u>Per Cent Primary</u>	<u>Secondary</u>	<u>Tertiary</u>	<u>Total</u>	<u>Nebr. Survey Per Cent</u>	<u>Nat'l. Health Survey Per Cent</u>
Blindness & Visual Impairment	10-11 12-13-14	12,546	7.78	2,831	229	15,755	8.02	9.78
Hearing	2	5,565	3.45	3,982	879	10,426	5.30	6.47
Orthopedic Deformity & Amputations	3-4	37,959	23.55	6,691	1,328	45,978	23.40	28.53
Emotional Disorders	50-51-52	12,933	8.03	696	125	13,754	7.00	8.53
Mental Retardation	53	8,808	5.47	881	-	9,689	4.93	6.01
Other Neoplasms	6	1,433	.89	474	-	1,907	.97	1.18
Allergies Etc.	61	24,126	14.97	3,541	2,335	30,002	15.27	18.62
Diseases of Blood & Blood Forming Organs	62	1,302	.81	-	-	1,302	.66	.81
Epilepsy and Other Neurological Disorders	63	3,984	2.47	239	-	4,223	2.15	2.62
Cardiac and Circulatory Disorders	64	35,960	22.31	4,332	771	40,914	20.82	25.39
Respiratory Disorders	65	5,417	3.36	921	305	6,643	3.38	4.12
Digestive System	66	2,834	1.76	1,463	1,384	5,681	2.89	3.53
Genito-Urinary Disorders	67	810	.50	288	-	1,098	.56	.68
Speech Impairment	68	4,451	2.76	662	-	5,113	2.60	3.17
Disabling Conditions N.E.C.	69	1,151	.71	354	-	1,505	.77	.93
Social, Economic								
Educational Deprivation	70	1,879	1.17	636	-	2,515	1.28	1.56
TOTAL		161,158		27,991	7,356	196,505		

TABLE IX

OCCUPATIONAL INFORMATION
ON
CHRONICALLY HANDICAPPED PERSONS
AS
OBTAINED FROM STATEWIDE CENSUS

Occupational Information on Chronically Handicapped Persons As Obtained From Statewide Census

V.R.A. Code	Disability	Professional	Managers Officials Proprietors	Farm Ranch Owners	All Clerical	All Sales Workers	Craftsmen Foremen and Kindred Workers	Operating and Kindred Workers	Private Household Workers	Service Workers	Laborers	Farm Laborers	Estimated Total Working Force	Unpaid Farm Workers	No Previous Employment	Retired	Housewives	School Age Children	Total	Unemployed	Total Chronically Disabled
1	Blind and Visual Impairment	591	-	389	229	917	-	-	-	682	-	186	2994	135	229	229	3093	1516	8196	4350	12546
2	Hearing Impairment	-	22	133	-	-	101	-	-	229	-	-	485	133	-	447	227	1437	2729	2836	5565
3	Orthopedic Deformity	2012	1003	2148	820	992	1612	858	514	1037	723	1003	12722	181	135	689	3102	6684	23513	12878	36391
4	Absence or Amputation-Limb	-	364	516	-	-	-	-	229	-	-	-	1109	-	-	-	-	-	1109	459	1568
50-51	Neuro- psychiatric	-	229	644	229	229	-	-	-	560	-	331	2222	-	-	-	586	1201	4009	1568	5577
52	Other Mental Disorders	-	-	-	229	-	-	-	-	229	-	-	458	-	229	-	282	5132	6101	1255	7356
53	Mental Retardation	-	-	-	-	-	-	-	-	-	-	-	-	-	229	-	-	6795	7024	1784	8808
60	Neoplasms N.E.C.	-	229	-	-	-	-	-	229	100	-	-	558	-	-	-	262	-	820	613	1433
61	Allergic, Endocrine, Matabolic, Etc.	1347	201	753	594	815	229	481	-	361	-	456	5237	-	-	-	2718	9405	17360	6766	24126
62	Diseases of Blood and Blood Forming Organs	-	-	-	-	-	-	-	-	-	-	-	-	-	229	229	331	460	1249	53	1302
63	Epilepsy and Other Disorders of Nervous System	-	-	-	-	-	364	-	-	217	-	-	581	-	-	-	688	1432	2701	1283	3984
64	Cardiac and Circulatory System	1374	710	1923	135	397	1303	584	235	961	560	482	8664	-	595	2298	5530	759	17846	18114	35960
65	Respiratory Diseases	559	181	217	135	-	-	490	-	-	-	-	1582	-	-	-	504	917	3003	2414	5417
66	Disorders of Digestive System	229	100	181	-	-	-	229	-	766	-	-	1505	-	-	-	237	364	2106	728	2834
67	Genito-Urinary System	-	-	126	-	-	-	-	-	135	-	-	261	-	-	-	-	134	395	415	810
68	Speech Impairment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4075	4075	376	4451
69	Disabling Diseases and Conditions, N.E.C.	-	-	-	-	-	-	-	133	-	-	-	133	-	-	-	135	230	498	653	1151
70	Educational Economic and Social Deprivation	-	-	-	-	-	229	-	-	-	-	135	364	-	-	-	-	-	364	1515	1879
Total:		6112	3039	7030	2371	3350	3838	2642	1340	5277	1283	2593	38875	449	1646	3892	17695	40541	103098	58060	161158

surveys points up that it is not practical to assume that National averages can be applied satisfactorily to the local or state level. When one compares the total of all levels of disabilities (primary, secondary and tertiary) obtained in the Nebraska sample with the total on the National Health Survey the difference in number is not too great (209,599 NHS to 196,505) and could be caused by any number of factors.

Occupational information is tabulated in Table IX utilizing the 18 classifications of disability referred to earlier in this chapter. Approximately 24% of the group are working at some type of job. There are 38,875 chronically disabled listed in eleven different occupational classifications. The largest disability group is that of the Farm or Ranch Owner, numbering 7030, followed by Professional Personnel (6112) and Service Workers (5277). Every group, with the exception of Sales Workers and Office Workers, report Orthopedic deformities and Cardiac and Circulatory System disorders as being the greatest areas of disability. The latter two occupational classifications report Orthopedic deformity and Allergies as being the two greatest areas of disability.

TABLE X

A TABULATION OF TYPE OF SERVICES
RENDERED DISABLED CHILDREN BY PUBLIC
AND PRIVATE HEALTH SERVICES
(1968)

<u>Agency</u>	<u>Medical Physical, Hospital</u>	<u>Phychiatric Services</u>	<u>Psychological Testing</u>	<u>Physical Therapy</u>	<u>Speech Therapy</u>	<u>Counseling Including Psychotherapy</u>	<u>Financial Aid</u>	<u>Provision of Artificail Limbs Braces, Hearing Aids</u>	<u>Dental Work</u>
1. Services for Crippled Children	3344	152	441	1276	898	-	1754	621	1701
2. Easter Seal Society	-	-	230	-	186	-	127	-	-
3. Public Schools	-	-	1460	671	3306	1955	186	-	-
4. County Assistance	1402	-	-	-	152	152	1689	230	543
5. Psychiatric Clinic	-	1443	1442	-	230	513	-	448	-
6. University Clinic	1556	152	704	-	1040	920	-	230	731
7. Service Clubs	338	-	-	-	-	-	-	488	-
8. Public Mental Retardation Facility	230	-	230	-	-	-	-	-	-
9. Public School for Handicapped	416	186	230	-	416	-	230	230	-
10. Private Physician	11803	508	253	-	-	-	-	439	152
11. Out of State Specialists	253	-	-	-	-	-	-	-	-
12. Private Dentists	382	-	-	-	-	-	-	-	1527
13. Birth Defects Clinics	127	-	-	-	-	-	-	290	-
14. Out of State School - Mental Retarded	-	-	-	127	-	127	-	-	-
15. Private Hospitals	517	230	267	483	-	-	-	-	-
16. Optometrists	-	-	-	-	-	-	-	152	-
17. Pediatric Hospital	388	-	-	-	-	-	-	230	230
18. State Hospital - Orthopedic	182	-	-	-	-	-	-	-	-
19. State Hospital - Mental	-	382	152	-	-	-	-	-	-
20. Medical Specialist	-	-	-	-	-	-	-	136	-
21. Jovenile Court	152	-	152	-	-	230	-	-	460
22. Parochial School	-	-	-	-	230	-	-	-	-

TABLE XI

A TABULATION OF TYPE OF SERVICES
RENDERED DISABLED ADULTS BY PUBLIC
AND PRIVATE HEALTH SERVICES
(1968)

Source of Services		Medical Surgical Hospital	%age	Provision of Prosthetic Appliances	%age	Dental Services; Dentures	%age	Psychological Testing	%age	Psychiatric Services Psychotherapy	%age	Physical Occupational Speech Therapy	%age	Total Medical Service	%age	Training For A Job	%age	Counseling And Guidance	%age	Assistance In Finding A Job	%age	Planning For A Job	%age	Total	%age
1.	Private Physician	33,054	39.58	4,693	33.30	-	-	-	-	-	-	186	4.19	37,933	29.77	-	-	-	-	-	-	-	-	-	-
2.	Private Hospital	26,509	31.74	1,751	12.42	1,131	9.72	500	7.06	720	10.81	1,241	27.97	31,852	25.00	-	-	134	2.39	230	4.12	-	-	364	1.75
3.	Veterans Hospital	6,391	7.65	646	4.58	1,377	11.83	1,653	23.34	1,241	18.63	702	15.82	12,010	9.43	230	3.60	646	11.54	690	12.37	416	12.86	1,982	9.53
4.	State Vocational Rehabilitation Services	2,928	3.51	956	6.78	136	1.17	816	11.52	357	5.36	278	6.27	5,471	4.29	4,358	68.21	2,259	40.37	1,579	28.30	899	27.78	9,095	43.73
5.	Private Dentist	-	-	124	.88	6,401	55.01	-	-	-	-	-	-	6,525	5.12	-	-	-	-	-	-	-	-	-	-
6.	Medicare	4,284	5.13	713	5.06	-	-	-	-	-	-	483	10.89	5,480	4.30	-	-	-	-	-	-	-	-	-	-
7.	University Clinic	2,874	3.44	1,020	7.24	814	6.99	-	-	230	3.45	460	10.37	5,398	4.24	-	-	-	-	-	-	-	-	-	-
8.	Psychiatric Clinic	136	.16	230	1.63	-	-	1,055	14.90	2,257	33.87	-	-	3,678	2.89	230	3.60	690	12.33	230	4.12	-	-	1,150	5.53
9.	County Welfare	2,430	2.91	389	2.76	952	8.18	-	-	304	4.56	-	-	4,075	3.20	-	-	382	6.83	-	-	230	7.11	612	2.94
10.	State Employment Services	-	-	-	-	-	-	509	7.19	-	-	-	-	509	.40	175	2.74	152	2.72	2,009	36.01	738	22.81	3,074	14.78
11.	State Hospital - Mental	530	.63	-	-	-	-	942	13.30	942	14.14	-	-	2,414	1.89	-	-	152	2.72	-	-	-	-	152	.73
12.	Veterans Administration	101	.12	-	-	230	1.98	230	3.25	-	-	-	-	561	.44	269	4.21	331	5.91	357	6.40	460	14.22	1,417	6.81
13.	Optometrists	-	-	1,588	11.27	-	-	-	-	-	-	-	-	1,588	1.25	-	-	-	-	-	-	-	-	-	-
14.	Medical Specialists	999	1.20	365	2.59	-	-	-	-	-	-	-	-	1,364	1.07	-	-	-	-	-	-	-	-	-	-
15.	State School for Mental Retardation	127	.15	-	-	-	-	628	8.87	-	-	-	-	755	.59	271	4.24	-	-	-	-	-	-	271	1.30
16.	State Hospital - Orthopedic	230	.28	416	2.95	230	1.98	-	-	-	-	230	5.18	1,106	.87	-	-	-	-	-	-	-	-	-	-
17.	Resident School for the Mentally Retarded (Private)	-	-	-	-	-	-	-	-	152	2.28	127	2.86	279	.22	127	1.99	127	2.27	127	2.28	127	3.92	508	2.44
18.	Service Organizations	230	.28	136	.96	-	-	-	-	-	-	-	-	366	.29	230	3.60	-	-	-	-	230	7.11	460	2.21
19.	Military Hospital	366	.44	290	2.06	-	-	-	-	-	-	134	3.02	790	.62	-	-	-	-	-	-	-	-	-	-
20.	School for Deaf	-	-	136	.96	136	1.17	-	-	-	-	460	10.37	732	.57	-	-	-	-	-	-	-	-	-	-
21.	Alcoholic Anonymous	-	-	-	-	-	-	230	3.25	230	3.45	-	-	460	.36	-	-	230	4.11	-	-	-	-	230	1.11
22.	Private Non-profit Evaluation Center	-	-	-	-	-	-	136	1.92	-	-	-	-	136	.11	271	4.24	-	-	-	-	136	4.20	407	1.96
23.	Outstate Rehabilitation Service	127	.15	-	-	-	-	-	-	230	3.45	-	-	460	.36	127	1.99	127	2.27	-	-	-	-	254	1.22
24.	State Hospital, T.B.	230	.28	-	-	-	-	-	-	-	-	-	-	230	.18	-	-	-	-	-	-	-	-	-	-
25.	Social Service Organization	-	-	-	-	230	1.98	-	-	-	-	-	-	230	.18	-	-	-	-	-	-	-	-	-	-
26.	Private Clinic Out of State	389	.47	-	-	-	-	-	-	-	-	-	-	389	.31	-	-	-	-	-	-	-	-	-	-
27.	Outstate Veterans Hospital	378	.45	-	-	-	-	-	-	-	-	-	-	378	.30	-	-	-	-	-	-	-	-	-	-
28.	Private Rehabilitation Center	152	.18	136	.96	-	-	-	-	-	-	-	-	288	.23	-	-	-	-	-	-	-	-	-	-
29.	Visiting Nurse Association	287	.34	-	-	-	-	-	-	-	-	-	-	287	.23	-	-	-	-	-	-	-	-	-	-
30.	Veterans Organization	-	-	136	.96	-	-	-	-	-	-	-	-	272	.21	-	-	-	-	-	-	-	-	-	-
31.	College and University Placement Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	136	2.43	127	2.28	-	-	263	1.26
32.	Miscellaneous	762	.91	370	2.63	-	-	382	5.39	-	-	-	-	1,514	1.19	101	1.58	230	4.11	230	4.12	-	-	561	2.70
Total:		83,514		14,095		11,637		7,081		6,663		4,437		1,514		6,389		5,596		5,579		3,236		20,800	

ARRAY OF OPINIONS EXPRESSED

RE: SALARY LEVEL BY REHABILITATION PERSONNEL D. R. S.

OTHER THAN ADMINISTRATIVE

	<u>OUTSIDE STATE</u>						<u>TOTAL</u>
	<u>NO OPINION</u>	<u>ADEQUATE</u>	<u>TOO LOW</u>	<u>ABOVE AVERAGE</u>	<u>LOW ENOUGH TO CAUSE DISSATISFACTION LOSS OF PERS.</u>	<u>HIGH ENOUGH TO ATTRACT PERSONNEL</u>	
ADEQUATE	0	2	4	0	2	0	8
TOO LOW	1	1	14	1	4	0	21
ABOVE AVERAGE	0	0	0	0	0	0	0
LOW ENOUGH TO CAUSE DISSATISFACTION LOSS OF PERS.	0	1	4	0	9	0	14
HIGH ENOUGH TO ATTRACT PERSONNEL	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL	1	4	22	1	15	0	43

INSIDE STATE

EDUCATION LEVELS AS REPORTED BY HEALTH SERVICE PERSONNEL

PROFESSION	N	LESS THAN HIGH SCHOOL		HIGH SCHOOL GRADUATE		SOME COLLEGE		TWO YEAR CERTIFICATE		LESS THAN BA		BA		SOME GRADUATE WORK		BD		MA		MD PHD OR EQUIV.	
PSYCHOLOGIST	34	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	6	27	-	-
SOCIAL WORKER	50	2	2	1	-	-	-	-	-	-	-	-	-	1	1	-	-	46	-	-	-
SPEECH & HEARING THERAPISTS	29	-	-	-	-	-	-	-	-	-	-	-	5	8	-	-	-	12	4	-	-
REHABILITATION SUPERVISOR	7	-	-	-	-	-	-	-	-	-	-	1	1	2	-	-	-	4	-	-	-
REHABILITATION ADMINISTRATORS	7	-	-	-	-	-	-	-	-	-	-	1	3	-	-	-	-	3	-	-	-
REHABILITATION COUNSELORS	26	-	-	-	-	-	-	-	-	1	5	11	-	9	-	-	-	-	-	-	-
OASI EXAMINERS	6	-	-	-	-	-	-	-	-	-	4	2	-	-	-	-	-	-	-	-	-
OCCUPATIONAL THERAPISTS	14	2	-	-	1	-	-	-	-	-	5	4	-	2	-	-	-	2	-	-	-
VISUALLY IMPAIRED COUNSELORS	9	-	-	1	1	-	-	-	-	1	4	2	-	-	-	-	-	-	-	-	-
WELFARE WORKERS	46	2	2	2	7	5	5	7	13	6	1	3	-	-	-	-	-	-	-	-	-
DEPT. OF LABOR	24	1	5	4	1	2	2	5	4	-	2	4	-	2	-	-	-	-	-	-	-
REHABILITATION COUNSELOR AIDES	3	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-
VETERAN SERVICE OFFICERS	12	4	3	1	2	2	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	267	11	12	15	8	15	43	44	1	87	31	-	-	-	-	-	-	-	-	-	-

Answer to Question:

Do you feel that your illness/injury has changed your overall ability to earn a living?

66,336	- Yes
46,004	- No
8,307	- No Response
120,647	Total

If yes, how?

<u>Number</u>	<u>Reason Given</u>
31,302	Physical limitation excludes them from performing most types of work.
13,903	Permanently disabled.
3,372	Unable to perform usual lin of work.
2,936	Visual problems.
2,600	Unable to hold any job for any length of time.
2,360	Progressive disability.
1,382	Confined to home-can only take home-bound activities.
1,281	Disability has reduced earning ability.
891	Unable to find work.
886	Unable to control symptoms.
722	Nervousness.
678	Lack of Education.
651	Hearing loss.
593	Excessive Absenteeism.
505	Necessity for frequent hospitalization.
460	Complete hearing loss.
412	Bad employment record.
386	Mental Retardation.
366	Epileptic Seizures.
230	Age and lack of Education.
152	Poor physical appearance.
127	Voluntary Retirement - Refuses medication or corrective surgery Etc.
127	Work load proportioned throughout various family members.
66,322*	Total Responses

* Rounding differences cause slight difference from "Yes" Responses above.

Answer to the Question:

What do you know about the State Employment Services?

25.36%	Responding indicated no knowledge.
61.06%	Responding indicate vague knowledge. (i.e. They help people get jobs.)
12.42%	Responding indicate greater familiarity. (i.e. Give employment tests, help place people in jobs.)
1.05%	Response indicating more than usual knowledge. (Same as above - familiar with unemployment compensation.)
.08%	Respondent well informed.
.03%	Respondent extremely well informed - Professional Knowledge.

Answer to the Question:

Has anyone in the household utilized the State Employment Service?

25.25%	No Response
5.89%	Yes
68.86%	No

Answer to the Question:

What do you know about the State Vocational Rehabilitation Services?

25.28%	Responding indicated no knowledge.
65.15%	Responding indicate vague knowledge. (i.e. They help handicapped people.)
8.13%	Responding indicate some knowledge. (i.e. They train and help handicapped people get jobs.)
.19%	Responding well informed
.06%	Responding extremely well informed - professional knowledge.

Answer to the Question:

Has anyone in the household applied for services or is anyone at present a client of the State Vocational Rehabilitation Services or Services for the Visually Impaired?

25.25%	No Response
1.02%	Yes
73.73%	No

HISTORY OF WORKMEN'S COMPENSATION AND

EMPLOYER'S LIABILITY

The Workmen's Compensation Laws can be rather complex for the layman to fully understand. Therefore, it was decided to include in this report a brief history of the law so the operation of the program and who it is designed to serve can be reasonably clarified.

The Workmen's Compensation Laws of the various states were established to provide the state with a just method of dealing with occupational disabilities.

In the past when an employee was injured on the job, he usually would have to sue his employer for damages and was faced with the major task of proving that his disability was the result of employer negligence.

As America became more industrialized the ratio of industrial accidents increased as did the number of personal injury suits instituted.

A review of the common law defenses of contributory negligence, assumption of risk, and negligent acts of other workers was found to be quite severe on the disabled worker and he was not receiving just compensation for his injury.

During the period from 1900 through 1910, many states adopted the employer's liability laws. However, the employee still had the problem of proving employer responsibility and negligence.

Nebraska enacted its first state workmen's compensation law in 1911, and made it an elective law in 1913. It has been revised over the years as needed. Essentially the basic Workmen's Compensation Laws maintain that industrial employers should assume the costs of occupational liabilities.

It has been noted by other writers that the current laws help to relieve the employer of the liability of common law suits which involve negligence.

The Chamber of Commerce of the United States in its 1968 edition of Analysis of Workmen's Compensation Laws points out that there are six basic objectives which seem to undergird the workmen's compensation laws. They:

1. Provide sure, prompt and reasonable income and medical benefits to work-accident victims, or income benefits to their dependents, regardless of fault;

2. Provide a single remedy and reduce court delays, costs and work loads - arising out of personal-injury litigation;
3. Relieve public and private charities of financial drains - incident to uncompensated industrial accidents;
4. Eliminate payments of fees to lawyers and witnesses as well as time-consuming trials and appeals;
5. Encourage maximum employer interest in safety and rehabilitation-through appropriate experience-rating mechanism; and
6. Promote frank study of causes of accidents (rather than concealment of fault) - reducing preventable accidents and human suffering.

Nebraska has an elective compensation law. In the case of the elective type of law, the employer may either accept or reject the Workmen's Compensation Act. However, in the case of rejection, the employer loses the three common-law defenses, i.e., assumption of risk, negligence of fellow employees, and contributory negligence. Employers under the Workmen's Compensation Act must insure their liability or they must qualify as self-insurers. If they do neither, they lose valuable legal rights. An employer who chooses to be a self-insurer is required to provide proof of financial ability or to deposit security acceptable to the Court to fulfill his obligations under the Act and to pay a premium tax.

Premiums paid by employers for compensation insurance are regulated by the Department of Insurance. Every insurance company authorized to write Workmen's Compensation Insurance must be licensed by the Nebraska Insurance Department. Insurance rates are affected by: The industry in which the employer operates; The employer's accident experience; The amount of "benefits" provided by law.

Employers pay full cost of insurance. Generally, if a firm's loss experience is lower than average for its industry classification, it pays reduced rates.

Usually the employer, under the Workmen's Compensation Act, is exempted from damage suits. If an employee rejects the Act, and sues an employer who has accepted it, the employer usually in this type of instance retains the three common-law defenses. Normally the Act is not rejected since the provisions of rejection make it impractical. Following is a condensed version of the Nebraska Workmen's Compensation Act:

SYNOPSIS OF THE NEBRASKA WORKMEN'S COMPENSATION ACT*

COVERAGE OF THE ACT:

Extends to the State of Nebraska and to every governmental agency created by it, and to every employer in the state employing one or more employees in the regular trade, business, profession or vocation of the employer.

Exceptions: Railroads engaged in interstate or foreign commerce.

May Elect to: Employers of household domestic servants.

Come Under :

The Act : Employers of farm and ranch laborers.

BY WHOM ADMINISTERED:

A court of four members.

COMPENSATION BENEFITS:

Benefits are payable on account of death or disability resulting from accidents or occupational disease caused by the employment and occurring in the course of employment which are two-thirds of average weekly wages lost because of disability, subject to a maximum limitation of \$45 per week. The minimum payment is \$30 per week.

Periods payable: For death: 325 weeks.

For permanent total disability, compensation payable for life.

For temporary disability, compensation payable for duration of disability, with maximum of 300 weeks.

SPECIFIC LOSSES:

Loss of an arm,	compensation payable for	225 weeks
Loss of a leg,	" " "	215 weeks
Loss of a hand,	" " "	175 weeks
Loss of a foot,	" " "	150 weeks
Loss of an eye,	" " "	125 weeks

For loss of any two of the above mentioned members of the body, compensation is payable for life.

MEDICAL EXPENSE:

The employer (or his insurer) is liable for all reasonable medical and hospital expense, including prescribed drugs, there being no limit on the amount payable except the needs of the case, and in addition to devices needed for treatment, the first prosthetic devices.

PROCEDURE IN DISPUTED CASES:

Either the employee or the employer (or his insurer) may file a petition for a hearing before the compensation court, which must be filed within one year of injury or last payment of compensation except where disability is latent and if latent, time limit is one year from date of knowledge of compensable injury. Original hearing is before one judge of the court.

Appeal may be taken directly to the district court or either party may request and have a rehearing before the three compensation judges sitting en banc, but must be made within fourteen days of the date of order on original hearing. Appeal may be taken from the judgment of the district court to the supreme court, which is final.

APPEARANCES IN DISPUTED CASES:

The employee, or the employer if a natural person, may appear in the trial of a disputed compensation case either with or without an attorney. If the employer (or his insurer) is a corporation rather than a natural person, he must be represented by an attorney.

SETTLEMENTS:

Settlements of compensation claims, whether or not they are disputed may be made by the parties without trial, but in any such case the settlement agreement to be effective must first be submitted to the compensation court for examination and approval and be in conformity with the provisions of the compensation law and to be final, must also be approved by district court.

WHO ARE ENTITLED TO BENEFITS:

Benefits are payable exclusively to the injured employee who survives the accident or occupational disease. In death cases the benefits are payable (within the 325 weeks limit) exclusively to the surviving spouse until remarriage or if there is no surviving parent and there are children under age 18 who were dependent upon the parent, they are entitled to certain benefits. A child over 18, if physically or mentally incapacitated for earning and if there is no surviving parent is also entitled to benefits. After remarriage, or if no surviving spouse, the remaining weeks if any are payable to any other persons who were in fact dependents of the deceased.

SECOND INJURY FUND:

In cases where the claimant was partially disabled from any cause, other than disease, prior to being employed, and suffers further disability as a result of an accident or an occupational disease in the course of employment, he is then entitled to compensation from his employer for the loss sustained in his employment, and thereafter if the combined disabilities are totally disabling, he is entitled to compensation for the remainder of his life out of the Second Injury Fund.

*This Synopsis was prepared by the staff of the Workmen's Compensation Court of Nebraska.

Many organizations and private citizens in this State have been interested and concerned about Workmen's Compensation and Rehabilitation. These people have noted that in the past years only a small percentage of disabled Nebraskans injured on the job and processed through the Workmen's Compensation Court have been referred on to the State rehabilitation programs. This has been due to the lack of staff being available to undertake the task of screening, referral and follow-up.

The Nebraska Manufacturers Association was formed in 1911 and 1912 by interested manufacturers in the State for the specific purpose of fostering and promoting and aiding in any way possible good workmen compensation laws. This organization and its successors, The Associated Industries of Nebraska and now the Nebraska Association of Commerce and Industry, have throughout the entire time that these laws have been on the statutes of the State done everything possible to promote and improve compensation legislation.

On March 31 and April 1, 1967, an institute was held on rehabilitation and workmen's compensation at the Nebraska Center for Continuing Education on the University of Nebraska campus at Lincoln, Nebraska. This meeting was conducted by the two state rehabilitation programs and by the Nebraska Workmen's Compensation Court. The National Institute on Rehabilitation and Health Services sponsored this meeting which was funded from a grant by the Vocational Rehabilitation Administration of the U. S. Department of Health, Education and Welfare. As a result of this meeting a communication was established between various groups involved in rehabilitation and workmen's compensation.

A few months later, it was decided that a representative from the Division of Rehabilitation Services should be assigned to the Workmen's Compensation Court for a brief period to undertake a review of the Compensation files to identify handicapped people who could potentially benefit from the rehabilitation services provided by the state rehabilitation agencies and to make referrals as needed. It was decided that this review should be undertaken only by a person with sound rehabilitation experience.

During the three-month period from June through August, 1967, Mr. Walt Koester, a rehabilitation specialist for the State of Nebraska, examined 11,443 accident reports in the Workmen's Compensation offices in the State capitol. As a result of this review, 78 referrals were made to rehabilitation agencies. The 78 referred had incurred an injury which would result in a permanent disability. It was apparent that these people would need the rehabilitation services offered by the state in order for them to return to gainful employment.

The breakdown of those referred during the three-month period is as follows:

Nebraska Division of Rehabilitation Services	64
Nebraska Services for the Visually Impaired	9
Iowa Division of Rehabilitation Services	2
Missouri Division of Rehabilitation Services	1
Colorado Division of Rehabilitation Services	1
Wyoming Division of Rehabilitation Services	1
	<u>78</u>

An additional 407 cases of those reviewed may or may not require the services of the State rehabilitation agencies. If it is found that the disability is of a permanent type, they will need services. The rehabilitation specialist, in a report covering this three-month period, indicated that these 407 cases would be followed up by examining the periodic reports that are submitted by the insurer and if it appeared that permanent disability would result from the injury, these people would be contacted immediately and referred on to the appropriate rehabilitation agency. He further pointed out that the State Rehabilitation staff included such a limited number of professional personnel that if the entire 407 cases had been referred to them all at one time, it would have made it extremely difficult for the agency to process all of the referrals and do it properly.

The report of the rehabilitation specialist indicated that the original assignment was to be temporary or part-time but a recommendation was made that this should result in a permanent assignment, recognizing the fact that early identification and referral of permanently disabled handicapped people is important if these people are to be successfully rehabilitated. The basic assignment would include activities of screening Workmen's Compensation reports with the purpose of referring cases to the appropriate rehabilitation agency in the state. This would also require follow-up to ascertain the outcome of the referral. It was indicated that the professional person assigned to this task would also need secretarial assistance in accomplishing his goal.

Through a cooperative effort between the Workmen's Compensation Court and the Division of Rehabilitation Services, the activities of the rehabilitation specialist have been continued in the Workmen's Compensation Court and have resulted in a third party agreement which is discussed elsewhere in this report. The rehabilitation specialist recently reported to a committee, on which the writer of this report is serving, the following information:

He indicated that during the period September 1, 1967, through September 30, 1968, 31,121 Workmen's Compensation disability report forms had been reviewed. Of this number 635 have been investigated for referral and of this number 253 had completed the referral process while 382 are still being worked up. State rehabilitation agencies have had 180 cases referred. A breakdown of this number was that 152 were referred to the Nebraska Division of Rehabilitation Services, 16 to the Nebraska Services for the Visually Impaired, and 19 to other states surrounding Nebraska. The rehabilitation specialist reported that of the cases referred, the Division of Rehabilitation Services of Nebraska has rehabilitated 7 while the Nebraska Services for the Visually Impaired has rehabilitated 1. An average cost per case that listed services purchased was \$583. The rehabilitation specialist has developed fact sheets and a good form letter to send to those cases he feels might qualify for rehabilitation services. It is the hope that the assignment of a rehabilitation specialist to the Workmen's Compensation Court will be continued since this is the beginning of setting up a good screening and referral program from the Compensation Court to the various state rehabilitation agencies. Although the numbers of people that will be initially referred to the state agencies may not be large, chances are these numbers will grow and a segment of the disabled in Nebraska will be served much more adequately than they have in the past.

*Copies of these forms are included in the Appendix.

In summary it is the opinion of the writer that Nebraska Workmen's Compensation Laws are among the best of all the states in the nation. They have been carefully and conscientiously studied, improvements made in other states in any specific field have been fostered in Nebraska by interested parties and basically they are very good. Amendments of course have been made as inflationary spiral has continued to increase the cost of living and both industry and labor have worked together to handle this in a very satisfactory manner.

Nebraska has been fortunate in having very fine and conscientious administrators of the law and at the present time we feel that we have a very dedicated personnel in the Compensation Courts. There are four judges handling the caseload and all have been very receptive to possible improvements and corrections as our social conditions and requirements change.

Since the employer pays the cost of benefits provided by the acts and these costs can be reduced by a lower experience rating, he has a financial as well as a humanitarian incentive for reducing job-connected accidents to an absolute minimum and for seeking maximum work rehabilitation.

Nebraska employers with the help of insurance carriers, their safety engineers, and expert plant safety advisors, have been making great progress towards the elimination of injuries and their efforts have been rewarded with reduced workmens compensation costs.

The Nebraska laws provide for rehabilitation services to restore injured employees as well as others to their maximum physical usefulness as nearly as possible to the physical status enjoyed before the injury.

The State Vocational Rehabilitation Division of the Department of Education can assist in vocational training. Placement facilities for the handicapped are available from the State Employers Security Division. Rehabilitation of injured employees is a desirable objective. All parties involved, doctors, patients, employers, insurance carriers, medical associations, organized labor, and others, should utilize all public and private facilities for rehabilitation. It pays.

It is the opinion of the writer that in this particular field we are offered our greatest opportunity for improvement. It is in line with these objectives that of course the previous referred to studies have been made. It is our opinion that laws should be introduced for legislative consideration that will better facilitate the Workmen's Compensation Court and the administration of rehabilitation services. They should be in a position to obtain the best services available from whatever source they can be obtained, whether public or private, whether from State rehabilitation, or from private industry. Close and conscientious supervision must be properly administered by the Court. Enabling legislation will be presented to our Legislature for their thoughtful consideration at the next session.

It is further the opinion of the writer that adequate funds are available to handle a very fine rehabilitation program. Assessment is made on premiums to the insurance companies for all expenditures of the Court. In the last four bienniums collections by the State on the basis of 2% have exceeded the expenditures by one million one hundred and forty-eight thousand five hundred and fifty-nine dollars. (\$1,148,559) This excess collection has gone into the State General Fund. These moneys should have been and should in the future be used for rehabilitation. Should there be any moneys left over after adequate services are performed, then it should be returned to the General Fund.

MENTAL RETARDATION, PAST, PRESENT, FUTURE

Report prepared by Ralph E. Garner
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State of Nebraska

Mental Retardation--Past

HISTORICAL SETTING:

Sufficient literature has been published and is available for detailed information of the historical developments of mental retardation, so only a few highlights will be listed in this report. As Seymour B. Sarason has shown, there was little or no organized interest in the mentally retarded up thru World War II and perhaps even to the time of the publication of the second edition of Sarason's book, Psychological Problems in Mental Deficiency. Certainly Itard and his pupil Seguin examined the problem formally. Their story of the so-called Wolf-boy is a presumed early classic. Some attention was given even earlier since as Michael-Smith recalls for us that the Spartans are presumed to have destroyed their defectives by tossing them over cliffs. We have all heard of the Chinese Compounds. Sarason and others have shown that perhaps it was due to the fact that parents finally organized and demanded that something be done that has brought about the growth of the present organized movement. Research in the field of retardation has grown by leaps and bounds since then. The first parent group was organized in the mid-1930's. The National Association of Retarded Children was formed in 1950. There are hundreds of local units and associations across the United States now. More and more universities and colleges are establishing departments of mental retardation. Training and treatment sections of medical schools like the Nebraska Psychiatric Institute, Indiana's College of Medicine, et al, are involved in intensive research. In fact the Report of the State of Nebraska to the White House Conference on Children and Young, 1960 stated ... "a Mental Retardation Project is in operation at the Nebraska Psychiatric Institute of the College of Medicine, University of Nebraska... It is one of a few projects in this country set up by the National Institutes of Health for study and research in the over-all problems of the mentally retarded. The project is the only known facility in this area, if not in the United States, for inpatient evaluation and study of retarded children under six years of age." PKU, mongolism and Down's Syndrome are receiving Public attention but these are only two of many studies in process. Literature has become extensive and in a quantity difficult to absorb. The Journal of the American Association on Mental Deficiency is filled with technical material. A second journal Mental Retardation had to be established to publish over-flow material. The National Association of Retarded Children, the Council of Exceptional Children and a few universities publish extensive material of both popular and semi-technical format. In 1960 the President's Conference on Children and

Youth included for the first time a section on Mental Retardation.

The above indicated new interest and emphasis resulted in the publication in 1959 by the American Association on Mental Deficiency of a monograph entitled A Manual on Terminology and Classification of Mental Retardation. Changes and new information forced a second edition two years later, or in 1961. The manual has become a classic, and the classification scheme devised is now generally accepted as the base from which reports, definitions, and research move forward and are refined. A third edition may soon be needed!

HISTORICAL SETTING, NEBRASKA:

The Beatrice State Home: The first organized concern in Nebraska as far as documentation is concerned comes from legislative action in 1885. Resultant legislation included statutes 83:218-227 established the "Nebraska Institution for the Feeble-minded," now called the Beatrice State Home.

Until the first half of the 1950's the Beatrice State Home was primarily a custodial institution. Statute 83:218 reads as follows:

School for the feeble-minded; purpose. The Nebraska Institution for the Feeble-minded shall provide custodial care and humane treatment for those persons who are feeble-minded, shall segregate them from society, shall study to improve their condition, shall classify them, and shall furnish such training in industrial, mechanical, agricultural and academic subjects as they may be capable of learning.

The institution lived up to its charge. In terms of the primary concern of this chapter shortly after a social service department was established in 1955, liaison was made with Nebraska's Division of Rehabilitation Services.

In 1957 the Agency established a counselor position to work with the retarded and to work part time with the Home. The success of the pilot work thus started led the Superintendent in his Biennial Report, July 1, 1957 through June 30, 1959 to recommend the inclusion on the full time staff a Vocational Rehabilitation Counselor. This position was established three years later in 1962. Six and one-half years on October 1, 1968, this program was expended into the beginnings of an organized rehabilitation training unit on the campus of the Beatrice State Home.

ASSOCIATIONS FOR RETARDED CHILDREN:

As noted on page one, in the mid 1930's somewhat spontaneously a few parents got together to discuss their mutual problems. By 1950 these parents felt that only by a united front could something be done to help them in their problem. The National Association for Retarded Children (NARC) was formed. In Nebraska the first parent groups or

"Units" were established in Fremont, Omaha, and Lincoln in 1953 and 1954. From that beginning the Nebraska State Association for Retarded Children was founded in 1955. It has grown to nineteen "units" and in August, 1966 employed its first full time secretary. All areas of the state are represented by the units. The Units sponsor various activities, but for the most part support special schools for the children of parents who are members of the group. Since 1967 some of these "schools" have been absorbed by school districts or by the newly developing State Educational Service Units. Three and possibly four of the parent units have now established adult Vocational Training Program.

REHABILITATION:

The concern for the welfare of the doughboy of World War I led to organized efforts of rehabilitation for them. The question was then raised that if these efforts were successful and useful for the returning soldier, could not the civilian population profit from similar help. In order to get things moving, our founding fathers discovered the necessity for Federal subsidization to state and local areas so as to build on a matching fund ratio, the corduroy roads of the 1780's and 1790's and we are still so doing even up to a 90-10 ratio for some roads. Down thru the years homestead grants, gifts of land to railroads to build lines (e.g., the Union Pacific), terracing, dams, canals, etc., are other examples of federal help. In 1920 pilot programs on the same principal of building roads were offered to the states to establish rehabilitation programs for the civilian population. For some 20 to 25 years the program concerned itself with orthopedic disabilities. In 1943 congressional permissive legislation began to broaden the scope of disabilities for which federal matching funds were available. Mental retardation was included in the list, but few people knew what to do. In 1947 additional federal help was provided and a few states began to attempt rehabilitation programs for the retarded. In 1954 Public Law 565 funds were made available to states to provide demonstration projects and to establish improvement programs. For the most part these were patterned after a pilot workshop training program sponsored by the New York City Association for the Help of Retarded Children.

REHABILITATION IN NEBRASKA:

Nebraska's counselors after 1947 cautiously tried to help a few retarded, many of whom were perhaps only functionally retarded. As was noted on page 3 in 1957 Mr. Novak, Assistant Commissioner of Education and Director of the Division of Rehabilitation Services approved the addition of a counselor to specialize in the rehabilitation of the retarded and to be a resource person to others on the staff. The need for special services to assist in the rehabilitation, and (as was soon indicated) more often the habilitation of the mentally retarded soon became apparent. The Division of Rehabilitation Services since then has provided resource help in the establishment of specialized training centers and workshops. The Nebraska Goodwill Industries in Omaha

was the first to provisionally make some adjustments to provide evaluation and training. However, as indicated in a 1954 report, while they had a workshop the concern was "serving particularly the physically handicapped and aged." "The Rehabilitation Survey" reporting this dealt briefly with the problem of Retardation and came to the conclusion that retardation was too big a problem. In terms of mentally retarded children and children with emotional disorders the report stated: "The enormous problems in these areas were not studied comprehensively, although the size and complexity may be even greater than for children with physical handicaps...With regard to the more seriously mentally retarded, there is the problem of the sustained great expense.

The Lincoln Goodwill Industries in 1960 became the first program to concentrate exclusively on evaluation and training of the retarded in this state. In cooperation with the rehabilitation counselor and for the first time, attempts were made to locate housing for the retarded away from institutions and from the parental home. The Martin Luther Home in Beatrice established the first private workshop in Nebraska exclusively concerned with evaluation and training of the retarded. Along with the MacDonald School in Florida they became one of the first two workshops to provide living-in facilities in a dormitory type setting so as to teach independent living along with vocational evaluation and training. Within the year 1968 at least three of the Units of the Nebraska State Association for Retarded Children have established local workshop training programs. These are the Lancaster Assoc. for Retarded Children, in Lincoln, Nebraska, the Norfolk Opportunity Center, in Norfolk, Nebraska and the Ragen Training Center in Ragen, Nebraska.

MENTAL RETARDATION--1968

DEFINITIONS AND ETIOLOGY:

It seems that one must always be concerned with the necessity to provide some statements on these points. Yet perhaps this is of importance. It reemphasizes the recency of organized concern for the retarded and the recency of the inauguration of research in retardation. It was indicated on page one that Itard made some studies a century and a half ago. Binet in part developed his tests to screen out the retarded from programs. For many years, then, the Intelligence Quotient or I.Q. was the criteria by which one was retarded or not retarded. William Frankel, long a leader in New York City in the field of retardation, and who has held various positions as teacher, director of workshops for the retarded, executive secretary of retarded associations, consultant to federal offices concerned with retardation participated in an institute on retardation at Iowa City, Iowa, May 9-13, 1960. He commented that there are many definitions of retardation. Some of these are: State Departments of education and /or legislative definitions, local school definitions and criteria, classification scheme of psychiatrists, classification schemata of psychologists, the World Health

organization's criteria, parents, doctors, and the American Association on Mental Deficiency, etc.

Nebraska State Department of Education: Nebraska's definition of the educationally mentally retarded seems quite broad. The basis for establishing the criteria is spelled out in a document distributed in 1954 by the Special Education Department of Nebraska entitled A Guide for Providing Programs for Handicapped Children. In terms of criteria the following seems important:

1. DEFINED: PURSUANT TO SECTION 43-604 (4). "The Term Educable Mentally Handicapped", Children of school age shall be considered EDUCABLE MENTALLY HANDICAPPED And eligible for Special Educational privileges under the following classifications:

Recommendation of a qualified psychologist* when the performance on an individual psychological evaluation falls between One(1) Standard Deviation and Two (2) Standard Deviations below the norm on the evaluative tool selected and administered by the qualified psychologist.

Provisional Qualification: Should the performance of a child fall below Two (2) Standard Deviations on a selected evaluation criterion the administering psychologist may qualify the child for inclusion and consideration under the following procedures:

- a. Recommendation of a second individual psychological evaluation.
- b. Clarification in writing as to the extenuating circumstances which might have influenced the reliability of the child's performance at the time of the second testing experience.
- c. Recommendation that the child be included provisionally for a specific period of time to be established by the local school board when the child's test performance does not fall below Three (3) Standard Deviations from the norm on the selected evaluation criteria.

*Qualified psychologist must hold membership in the American Psychological Association.

Three years later in 1957 the above was translated into an I.Q. chart:

<u>Descriptive Classification</u>	<u>I.Q. Range</u>	<u>Approximate Adult Mental Level</u>
Slow Learning or Dull	80-90+	12-14 Years
Mildly Retarded or Educable	55-80+	8-12+ Years
Moderately Retarded or Trainable	30-55	4-8 Years
Severely Retarded or Totally Dependent (Custodial)	0-30	0-4+ Years

It may be noted that the above are in Standard Deviation terms. The 1957 report goes on to discuss overlappings, differences, special characteristics and the need for special understanding by teachers.

The above excluded the moderately retarded for most programs. A revision in 1964 dropped the Standard Deviation point listed in number one above to 2.5. During the 1967 legislature at least 15 bills were passed which pertained directly or indirectly to the mentally retarded. Pertinent to rehabilitation was the encouragement of the development of classes for the so-called trainable, and the provision of some funding for special classes.

The American Association on Mental Deficiency. It has been indicated several times above that the classification scheme of the American Association on Mental Deficiency is an increasingly well accepted standard from which to base decisions, regulations, and research. The definition as given is as follows:

"Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." 1. Subaverage is defined as performance which is greater than on Standard Deviation below the population mean of the age group involved on measures of general intellectual functioning. General Intellectual functioning relates to performance on one or more of the various objective tests which have been developed for that purpose. The definition of "developmental period" was left partly open, but the age of 16 was suggested as a probable criterion. Impaired adaptive behavior is defined as being reflected in (1) maturation, (2) learning, and/or (3) social adjustment.

A plethora of material exists with respect to intellectual functioning. Less well understood is adaptive behavior. The above mentioned Manual of the American Association on Mental Deficiency presented a chart presented by Sloan and Birch. It illustrated levels of Adaptive Behavior for three broad groups. It is not shown here, but a modification presented by the President's Panel on Mental Retardation has been accepted for publication in Blue Print for Action: The Nebraska Plan to Combat mental Retardation. It is shown in Chart I.

For working purposes, the two part definition reflects current knowledge, and seems to be well enough accepted to provide a base to consider programs for the future.

Etiology. This is a fast changing area of study. Neurological studies, chromosomal studies, endocrine studies, the behavioral sciences and even sociological studies all result in constantly changing concepts. Because of this state of flux, the etiology of retardation cannot be stated in definitive terms. Suffice it to say that in 1968 there does not seem to be one cause of retardation, rather many. Any programming in the field of retardation will need to be able to reflect any new knowledge or information applicable to such programming.

Rehabilitation Status in 1968. The following chart indicates the increased numbers of those rehabilitated who were diagnosed by Nebraska as being mentally retarded:

1954-1955	11**
1955-1956	17
1956-1957	23
1957-1958	22
1958-1959	36
1959-1960	27
1960-1961	28
1961-1962	45
1962-1963	49
1963-1964	64
1964-1965	82
1965-1866	*
1966-1967	*

*No breakdown was available for each year, but for the biennium 214 or an average of 107 each year were rehabilitated.

**Figures taken from annual reports of the Division of Rehabilitation Services, Nebraska State Department of Education.

It was noted in the introductory part of this chapter that counselors after 1947 began to work with a few of the retarded. It was also noted that Public Law 565 in 1955 provided greater emphasis for many disabilities including retardation. Two interpretations are offered for the trends indicated in the figures. The establishment of the position of a counselor specializing in retardation along with the additional assistance of public Law 565 in initially providing the establishment of the position constitutes a primary factor in the increased number rehabilitated. It took time for counselors in the state to gain confidence that the retarded could be helped. The second major factor relates to the establishment of workshops and training centers. An earlier referral in this report shows that not until the year 1960 was the first training center for the retarded started. It took three years of planning to get this established. It took four more years of planning before the second workshop was established. It will also be noted that nearly a two year gap took place after the establishment of each training center. For the record it should also be noted that all three training centers (including Omaha) are not so-called terminal workshops. They have as their primary and usually sole objective the training for jobs. The Nebraska Goodwill Industries at Omaha, in contrast to the report of 1954 mentioned earlier, now also includes the retarded in its program and makes special provision for their training alongside and when possible a part of their training program for all disabilities.

A third factor in the figures of 1962 to 1964 was the establishment of a full time counselor at the Beatrice State Home and since about 1965 the help of two assistants.

Another statement needs also to be made with respect to the statistics. When the counselor specialist was hired in 1957 he was instructed that

it was not wise to try to serve those with IQ's below 50 or 55. Since this specialist was not prohibited, however, some cases were accepted. No records were kept but it is estimated that up to twenty persons with quotients below 60 have been placed in jobs, including perhaps a half dozen or more below 50. At least three of these were mongoloids and perhaps four. Another point which should be noted is that an increasing number of those in the program have several disabilities. Dr. Matilda McIntire of the Nebraska Psychiatric Institute has stated that the average institutionalized retardate has $3\frac{1}{2}$ disabilities. Certainly those in the general population have more than one. Counselors are more and more working with retardates with multiple handicaps. The number rehabilitated each year rises despite the increased costs of restoration and training and the increased time needed to train.

REHABILITATION OF THE MENTALLY RETARDED - THE FUTURE

When one considers that prior to 1950 no efforts were made to assist the retarded and that only 13 years ago only 11 were helped and 13 years later the figure is 107, the only conclusion which can be drawn is that progress has been made and that the time, effort and cost is well justified. Dollar comparison of wages between 1955 and 1967 cannot with justification be made without an exhaustive statistical analysis taking into account the growth of the general economy, inflation, analyses of increased productivity of both workers and the machines they operate. From statistics available for 1957-58 the wages of mentally retarded cases rehabilitated by the general agency ranged from \$60.00 per month to \$212.00 per month. In 1967-68 the wages ranged from \$120.00 per month to \$364.00 per month. Jobs in the past have been routine jobs, and usually social service jobs, such as janitorial, dishwashing, kitchen helpers, etc. Even in these areas, the retarded have become skilled workers. Perhaps the most apt expression, the most succinct one was the very confident statement of one client that "I'm the best damn dishwasher in the city of Lincoln".

The Future Needs:

1. A counselor assigned to each district office of Rehabilitation Services specializing in habilitation and rehabilitation of the retarded and acting as a coordinator for the area served by the district.
2. A vocational adjustment coordinator in all high schools of any size.
3. An intensive in-service training program for rehabilitation personnel serving the retarded.
4. An alternate proposal is a rehabilitation counselor for every population center, initially perhaps one for every fifty or sixty thousand population area. As more retarded become productive workers, however, a small part of that production will be needed for an increased number of counselors as noted in No. 5.
5. Consideration of assignment of counselors for in perpetuity counseling for the retarded. Most employed persons need help when job changes occur, when technological changes eliminate jobs, when personal problems reflect themselves in job performance. Private employment agencies, ministers, social workers, welfare workers, supply help from

time to time. Specialists even in the general area make for speedier transition and reduced time spans between jobs, or helping those with problems. Retardation specialists are also needed.

6. Expansion of the present workshops to train the retarded, or an increased number of such workshops.

Pre-School Age 0-5	School Age 6-21	Adult 21
Maturaton and Development	Training and Education	Social and Vocational Adequacy
<p>Level - I</p> <p>Gross retardation; mininal capacity for functioning in sensori-motor areas; needs nursing care.</p>	<p>Some motor development present; cannot profit from training in self-help; needs total care.</p>	<p>Some mctor and speech development; totally incapable of self-maintenance; needs complete care and supervision.</p>
<p>Level - II</p> <p>Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.</p>	<p>Can talk or learn to communicate; can be trained in elemental health habits; cannot learn functional academic skills; profits from systematic habit training. ("Trainable")</p>	<p>Can contribute partially to self-support under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.</p>
<p>Level - III</p> <p>Can talk or learn to communicate; poor social awareness; fair motor development; may profit from self-help; can be managed with moderate supervision.</p>	<p>Can learn functional academic skills to approximately 4th grade level by late teens if given special education. ("Educable")</p>	<p>Capable of self-maintenance in unskilled or semi-skilled occupations; needs supervision and guidance when under mild social or economic stress.</p>
<p>Level - IV</p> <p>Can develop social and communication skills; minimal retardation in sensori-motor areas; rarely distinguished from normal until later age.</p>	<p>Can learn academic skills to approximately 6th grade level by late teens. Cannot learn general high school subjects. Needs special education particularly at secondary school age levels. ("Educable")</p>	<p>Capable of social and vocational adequacy with proper education and training. Frequently needs supervision and guidance under serious social or economic stress.</p>

Level	Pre-School Age 0-5 Maturation and Development	School Age 6-21 Training and Education	Adult 21 and over Social and Voca- tional Adequacy
Profound	Gross retardation; minimal capacity for functioning in sensory-motor areas; needs nursing care.	Obvious delays in all areas of development; shows basic emotional responses; may respond to skillful training in use of legs, hands and jaws; needs close super- vision.	May walk, need nursing care, have primitive speech; usually benefits from regular physical activity; incapable of self maintenance.
Severe	Marked delay in motor development; little or no communication skill; may respond to training in elementary selfhelp, e.g., self-feeding.	Usually walks barring specific disability; has some understanding of speech and some response; can profit from systematic habit training.	Can conform to daily routines and repetitive activities; needs continuing direction and supervision in protective environment.
Moderate	Noticeable delay in motor development, especially in speech; responds to training in various self-help acti- vities.	Can learn simple communi- cation, elementary health and safety habits, and simple manual skills; does not progress in functional reading or arithmetic.	Can perform simple tasks under sheltered conditions; partici- pates in simple recreation; travels alone in familiar places; usually incapable of self maintenance.
Mild	Often not noticed as retarded by casual ob- server, but is slower to walk, feed self and talk than most children.	Can acquire practical skills and useful reading and arithmetic to a 3rd to 6th grade level with special education. Can be guided toward social con- formity.	Can usually achieve social and vocational skills adequate to self maintenance; may need occasional guidance and support when under unusual social or economic stress.

Source: The President's Panel on Mental Retardation, Mental Retardation, A National Plan for a National Problem
Chart Books, U.S. Dept. of Health, Education, and Welfare, Washington, D. C., 1963, p. 15.

HOME ECONOMIST REHABILITATION IN NEBRASKA

The home economist has been active as a member of the rehabilitation team at various centers and in certain programs throughout the United States since 1953. The home economist brings a unique background in rehabilitation counseling and homemaking rehabilitation to the aid of the physically disabled who are experiencing difficulty with their homemaking responsibilities, the severely disabled, and the homebound. Three projects in homemaking rehabilitation as conducted by the University of Nebraska School of Home Economics in cooperation with various other health-related and rehabilitation agencies are currently adding new dimensions to rehabilitation as practiced nationally. The School of Home Economics' responsibilities in these programs is under the direction of Dr. Virginia Y. Trotter, Associate Dean of the College of Agriculture and Home Economics.

These programs center on three concepts:

- 1) Mobilization of community resources on behalf of the disabled through a county-by-county homemaking rehabilitation program.
- 2) Provision of direct case services to the severely disabled men and women who are in the home and may be helped to assume homemaking responsibilities.
- 3) Provision of a training program at the graduate level which prepares the home economist and others in the paramedical field for positions in homemaker rehabilitation.

The first of these programs was made possible by a grant from the Nebraska Heart Association to the School of Home Economics. It initiates an "educational approach" to the general public to present and try out ideas for simplifying activities related to care of home, family and self in relation to the physically limited individual, her family, and other members of the general public who are concerned with the progress and development of a handicapped individual. This program makes use of a Mobile Unit, "Homemaking Unlimited", which presents a teaching program for homemakers with cardiovascular involvements, amputations, paraplegia, arthritis, visual impairments, and other physical handicaps. The Mobile Unit was made possible by a grant from the Nebraska Heart Association to the School of Home Economics. The Unit, along with a specially trained Homemaker Rehabilitation Consultant, travels throughout Nebraska presenting a special "rehabilitation program" demonstrating aid to the homebound physically handicapped individual.

The interior design of the mobile unit utilizes the research findings of homemaker rehabilitation studies conducted by various schools of home economics, the Institute of Rehabilitation Medicine of New York University, and home economists of the U. S. Department of Agriculture. Home Economics experts in rehabilitation were consulted, and physically disabled homemakers contributed ideas based on their experiences. The result is a practical presentation of a series of ideas that can be simply adapted in the home.

"Homemaking Unlimited" is modularly planned so that any one idea can be used independently of the others. The kitchen centers provide for working while seated -- a feature adapted especially for the person in a wheel chair or with limited energy. Many work simplification principles have been incorporated so that equipment and food are within easy reach of the seated person. Devices for persons with the use of only one arm are displayed, such as the vegetable holder. One storage unit features cleaning and laundry equipment that is particularly easy to see, reach, grasp, and handle. Holding bars for the bathtub and toilet have been planned for use by persons with any type of physical limitation.

Since limited physical activity means a change in food habits, a balanced diet to help weight control is important. Illustrated material giving special attention to this problem is displayed in the coach. Continuously shown color slides depict a physically limited mother caring for her child. Actual clothing having easy-to-put-on features and adaptations for specific disabilities is another important demonstration area in the coach. Well-illustrated bulletins also have been prepared for free distribution.

The "Homemaking Unlimited" project is programed through the University of Nebraska Cooperative Extension Service. It was started with a workshop for selected Extension home economists in July 1966. Julia Judson of the University of Vermont was key resource person and Dr. Elizabeth May, formerly of the University of Connecticut, served as a special consultant. Other consultants in the field of medicine and paramedical and related areas contributed to the orientation on various aspects of homemaker rehabilitation. Valerie Kehm is currently rehabilitation consultant working with this phase of the program.

Each county program now has a local advisory committee composed of Extension Service staff and representatives of the medical profession, the woman's auxiliary to the local medical society, the home builders, the clergy, as well as the home economists, nurses, occupational and physical therapists, hospital administrators, nursing home operators, the volunteer health groups and other interested citizens. Members of the homemaker rehabilitation staff of the University work closely with each local advisory staff to develop plans for intensive use of the coach in the county.

During the past two years the coach and consultant has been programed in twenty-three counties with the following contacts:

COUNTY	PUBLIC SHOWING	GROUP PROGRAMS	PERSONS CONTACTED	PERSONAL CONSUL- TATIONS	CARDIAC	PARA- PLEGIC	ARTH- RITIS	POST POLIO	ARM HAND	OTHER
Buffalo	10	4	840	20	6	--	4	1	1	8*
Chase	7	10	216	27	6	1	12	3	1	4*
Custer	7	13	820	22	6	1	1	5	1	8*
Dawson	12	16	2100	21	2	4	4	4	1	6
Dodge	2	14	486	18	2	--	5	1	1	9
Hall	4	10	658	22	3	--	5	4	1	9
Holt	12	10	409	22	6	--	8	--	1	7
Lancaster	9	11	494	36	10	--	2	6	2	16
Northeast Area										
Cedar	8	11	532	10	--	1	5	1	--	3*
Dakota	3	2	87	6	2	--	3	1	--	--
Dixon	2	1	114	3	--	--	1	1	--	1
Thurston	2	--	47	10	--	--	1	3	--	6***
Wayne	5	4	250	3	1	--	--	--	--	2
Platte	2	10	503	8	1	1	1	2	1	2*
Red Willow	--	10	115	22	6	--	6	--	--	10**
Saunders	8	11	562	18	4	1	2	4	--	7*
Scotts Bluff	6	8	602	22	5	8	5	2	2	--
Southwest Area										
Dundy	5	1	93	15	--	--	8	--	--	7*
Frontier	4	1	157	8	--	--	3	1	--	4*
Furnas	4	1	46	14	2	--	7	--	--	5***
Hayes	3	1	81	2	--	--	2	--	--	--
Hayes	7	1	105	12	4	--	7	--	--	1
Hitchcock	7	15	502	20	4	1	7	3	1	4
York										
Total	129	165	9,819	361	70	18	99	42	13	119

*Indicates one visually impaired person included.

The approximate cost of the program is as follows:

Initial payment for coach	\$30,000.
Yearly salary for consultant and program costs	\$25,000.

In Nebraska the program was initiated with a grant for the coach from the Nebraska Heart Association in 1964. Current salary and program costs are paid from funds available from the Nebraska Heart Association and the State Health Association.

In three counties, local committees formed for the "Homemaking Unlimited" program have continued to function. They have taken up new projects on behalf of the physically handicapped, such as the survey of buildings for architectural barriers as conducted in cooperation with the Nebraska Society for Crippled Children and Adults.

The second program listed above dealing with provision of direct case services to disabled people was instituted as a cooperative effort between the University of Nebraska School of Home Economics and the Department of Education, Division of Rehabilitation Services. This program involves use of a second "Homemaking Unlimited" coach equipped similarly to the first coach but with some refinements resulting from previous experience. This coach was financed in part under terms of an Innovation Grant from the Rehabilitation Services Administration and in part from a Third Party Agreement between the State Division of Rehabilitation Services, the University School of Home Economics and Rehabilitation Services Administration. This Unit will be operated by a specially trained rehabilitation consultant from the University School of Home Economics who is also a counselor for the State Division of Rehabilitation Services. The coach was delivered October 1. Alice Burton is the Consultant-Coordinator for the Unit. Under a Third Party Agreement the University of Nebraska supplied, in cash or in-kind, ten percent of the initial matching money necessary for the innovation grant as well as a percentage of the matching funds necessary to cover additional program expenses which are in excess of the amount available through innovation grants. The third party agreement also provides for sharing of responsibility for operation of the Coach. It is anticipated that the total cost of the program will be in excess of the amounts generated by innovation grant or third party agreement but that these expenses for direct services to clients will be absorbed as a part of the general program expense of the Division of Rehabilitation Services.

It is hoped that this program will show the effectiveness of the rehabilitation home economist and a rehabilitation coach in working with the person who is presently at home and needs help in learning to cope with and improve in the environment of the home. Specialists in rehabilitation consider this a first step in any rehabilitation program if the person is to advance to any work outside the home.

It is planned that the program will work with fifty individuals during the first year.

The third program listed above to provide training at the graduate level to prepare home economists and others in the paramedical field for positions in Homemaker Rehabilitation has been a long-time interest of the University of Nebraska School of Home Economics. This training program was initiated in September, 1966, through a grant from the Rehabilitation Services Administration. Dr. Lois O. Schwab serves as coordinator for this phase of the program. Work is offered at the masters and/or doctoral level in Home Economics to graduate students for working with the physically disabled individuals as a member of the rehabilitation team. Students completing the program will be professionally competent in helping physically disabled men and women and their families solve problems related to homemaking activities. These graduates will qualify for employment by local, state, or federal health departments and organizations, university extension and teaching programs, rehabilitation services and centers, medical schools and other university research programs.

The course work in homemaker rehabilitation is offered through the Department of Family Economics and Management with four courses in homemaker rehabilitation. Briefly, these are described as follows:

Family Economics and Management 241

Introduction to Homemaker Rehabilitation (1 - 3 credits)

The course introduces vocational rehabilitation as a field of study and the agencies active in it. Homemaker rehabilitation as a new area is reviewed in concept and development. Major projects and literature sources for the home economists in rehabilitation are reviewed.

Family Economics and Management 341

Home Management for the Homemaker with
Physical Limitation (3 credits)

Home management concepts are applied to the work and environment of the physically disabled individual. Research and demonstration projects conducted in the specific areas of work simplification, body mechanics, equipment selection, home planning, adaptation of clothing are studied for techniques and principles.

Family Economics and Management 342

Seminar in Homemaker Rehabilitation (1 - 3 credits)

Presentations are made by class members and other university staff members on the key concepts in psychology of physical disability, rehabilitation counseling, adult education, and etiology and medical care for physical disability (this latter subject to become a separate course in the future). Papers may be prepared on subjects as the disabled child, the aged individual, the visually impaired.

Family Economics and Management 343
Field Work in Homemaker Rehabilitation (2-4 credits)

Students are given the experience of working with clients in a variety of rehabilitation settings, including the "Homemaking Unlimited" coach, the home and hospital.

In addition, students take the course in Principles and Philosophy of Physical Medicine and Rehabilitation at the University of Nebraska College of Medicine.

In this course, various fields of work or specialty concerned in the total approach to evaluation and treatment of disabled persons are reviewed as well as the principles and philosophy of physical medicine and rehabilitation. The course is presented in lecture, demonstration and conference forms.

Eight students are working for the Master of Science degree and two students are studying for the Doctor of Philosophy degree in preparation for positions in homemaker rehabilitation.

In June 1966 a state-wide Advisory Committee in Homemaker Rehabilitation was formed to give guidance to the various phases of the program.

Members of the committee represent state rehabilitation agencies, the state health department, University health services, related health and paramedical disciplines such as Social Work, Medicine, and Educational Psychology as well as various areas in home economics. This group meets to review, make suggestions and evaluate current phases of the homemaker rehabilitation program. The members of the advisory committee and their affiliation are as follows:

Chairman, Dean
Virginia Y. Trotter, Ph.D.
School of Home Economics
University of Nebraska

S. I. Fuenning, M.D.
Director
University Health Center

Dwight M. Frost, M.D.
Chairman, Physical Medicine
and Rehabilitation
College of Medicine
University of Nebraska

Mrs. Naomi Brill, Asst. Prof.
School of Social Work
University of Nebraska

Fay Smith, M.D.
Assistant Dean and Professor
of General Practice
College of Medicine
University of Nebraska

Lynn Thompson, M.D.
Director
Nebraska Health Department

Anthony J. Carnazzo, M.D.
Creighton Medical College
Omaha, Nebraska

Royce Ronning, Ph.D.
Chairman,
Educational Psychology
University of Nebraska

Howard W. Ottoson, Ph.D.
Director,
Agr. Experimental Stations
University of Nebraska

Fred Novak, Director
Nebraska Division of
Rehabilitation Services
Department of Education

Marion Clark, Director
Nebraska Services for the
Visually Impaired, Dept.
of Institutions

Robert Draney
Facilities Specialist
Nebraska Division of
Rehabilitation Services
Department of Education

Mrs. Calista C. Hughes
State Senator
Humboldt, Nebraska

Arnold Baragar, Chairman
Family Economics & Management
School of Home Economics
University of Nebraska

Miss Valerie Kehm, Instructor
Family Economics & Management
School of Home Economics
University of Nebraska

A. L. Smith, Jr., M.D.
Lincoln, Nebraska
President of the Nebraska
Heart Association

Miss Agnes Arthaud
State Home Extension Leader
University of Nebraska

Mrs. Clara Leopold
Associate Professor
Family Economics & Management
University of Nebraska

Jack Hobbs, Director
Statewide Comprehensive
Planning for Rehabilitation
Services

Mrs. Fern H. Orme
State Senator
Lincoln, Nebraska

Helen Becker, Associate Prof.
Extension Specialist in
Health Education
University of Nebraska

Dr. Hazel Fox, Chairman
Food and Nutrition
School of Home Economics
University of Nebraska

Miss Alice Burton, Instructor
Family Economics and Management
School of Home Economics
University of Nebraska

Lois O. Schwab, Ed. D.
Associate Professor
Family Economics and
Management
School of Home Economics
University of Nebraska

In addition, a new homemaker rehabilitation laboratory in the home economics building will be completed in Fall 1968. This will provide two-level kitchen working heights for the seated ambulatory worker and a bathroom for individuals using a commode chair.

A library of research bulletins, books, periodicals and films on various aspects of rehabilitation of the physically handicapped in the home is maintained along with the teaching program.

The indications of interest in the Nebraska program have been nationwide from both the private and public agencies. It is hoped that through these new programs, more effective services will be extended to the physically disabled who remain home.

PHYSICAL RESTORATION PERSONNEL SURVEY - PHYSICIANS

A short, one page questionnaire was prepared to be mailed to all physicians listed in the membership of the Nebraska Medical Association. With the help of Dr. Richard Booth, a compact questionnaire was designed. Cover letters signed by Dr. Booth accompanied the questionnaire. In three mailings an 81.1% response was achieved which is considered excellent for questionnaires of this nature. A response of this nature can indicate a rather wholesome interest on the part of this group in rehabilitation. Of the 1,267 physicians contacted, 1,028 responded.

The tabulations reported here are by no means to be considered final, but as a preliminary work-up to assist in debugging the tabulation process and computer programming. The figures presented here are in the terms of numbers responding and no attempts are being made at the present to give relationships, saturations and other important data which will relate to the final study. They are also indicative of the type of cooperation one can expect from this important population segment.

The accompanying map shows the distribution of physicians per county responding to the questionnaire as well as those willing to serve on committees or interested in the research in process. Of the 1,028 responding, 47.3% indicate an interest in serving. It will be noted that these are well distributed over the entire State map and should provide an excellent cooperative nucleus with which to work.

The major specialties are well represented. The distribution is tabulated below. The largest representative group are those engaged in general practice. Internal Medicine and General Surgery are second and third largest specialties respectively.

In the sub-specialties, again most all of the main fields are represented with the addition of rather highly specialized areas within specific sub-groups. These will be reclassified with the help of a physician for more meaningful presentation in final report form. Of those reporting specialties, 324 indicate board certification. There are 26 persons that specify board certificates in sub-specialties. There are 251 interested in further graduate studies in their sub-specialty interests. These areas together with the numbers of physicians expressing interest will be presented in a more complete report at a later date.

-and-

NUMBERS INDICATING A WILLINGNESS TO SERVE ON COMMITTEE WORK



0 - Top number indicates number of responses

-0- - Those demonstrating an interest or willingness to serve on a committee.

TABLE I
DISTRIBUTION OF PHYSICIANS SPECIALTIES AND SUB-SPECIALTIES
N=1,028

<u>MAJOR SPECIALTIES</u>	<u>SUB- SPECIALTIES</u>	
9	0	Administrative Medicine
2	5	Allergy (sub-specialty of Internal Medicine)
19	2	Anesthesiology
3	9	Cardiovascular Disease (sub-specialty of Internal Medicine)
0	3	Child Psychiatry (sub-specialty of Psychiatry)
2	1	Colon and Rectal Surgery
7	2	Dermatology
0	3	Gastroenterology (sub-specialty of Internal Medicine)
434	4	General Practice
1	2	General Preventive Medicine (special field of Preventive Medicine)
88	21	General Surgery
114	4	Internal Medicine
5	0	Neurological Surgery
3	6	Neurology
57	3	Obstetrics and Gynecology
0	2	Occupational Medicine (special field of Preventive Medicine)
39	4	Ophthalmology
29	2	Orthopedic Surgery
22	2	Otolaryngology
28	0	Pathology
39	2	Pediatrics
0	1	Pediatric Allergy (sub-specialty of Pediatrics)
0	1	Pediatric Cardiology (sub-specialty of ")
1	1	Physical Medicine and Rehabilitation
2	1	Plastic Surgery
38	4	Psychiatry
2	1	Public Health (special field of Preventive Medicine)
1	3	Pulmonary Diseases (sub-specialty of Internal Medicine)
35	1	Radiology
3	5	Thoracic Surgery
18	0	Urology

Table I - Cont'd

<u>MAJOR SPECIALTIES</u>	<u>SUB- SPECIALTIES</u>	
0	48	Miscellaneous Sub-Specialties
27	885	Not Specified
<u>1,028</u>	<u>1,028</u>	

The majority of physicians (790) indicate they are engaged in full time practice. A small number (62) are in full time institutional work. The balance divide their time in varying ratios between private practice, teaching and institutional work.

Surprisingly 398 physicians are not affiliated with any hospital. No analysis has been done as yet within this particular area, but it is empirically evident that some are not close enough to a hospital to be able to make use of these resources.

TABLE II

RESPONSES TO SPECIFIC QUESTIONS EXPRESSED IN PERCENTAGES
AND NUMBERS

	<u>YES</u>	<u>NO</u>	<u>NO RESPONSE</u>
Numbers and Percent of Physicians Expressing knowledge of General Rehabilitation Services.	547 53.2%	390 37.9%	91 8.9%
Numbers and Percent of Physicians Expressing knowledge of Services for the Visually Impaired	422 41.1%	493 47.9%	113 10.9%
Numbers and Percent of Patients referred by Physicians to General Rehabilitation Services	501 48.7%	320 31.1%	207 20.2%
Numbers and Percent of Patients referred by Physicians to Services for Visually Impaired	240 23.3%	488 47.5%	300 29.2%
Numbers and Percent of clients referred to Physicians by both services	482 46.9%	242 23.5%	304 29.6%
Did the Services rendered by Rehabili- tation meet with your satisfaction?	466 45.3%	40 3.9%	522 50.8%
Numbers and Percent of Physicians interested in further information and participation in the project	496 48.3%	407 39.6%	125 12.1%

Table II gives the percentage response to various questions asked of the physician with regard to their experience with the rehabilitation services. All percentages are based on the responses of 1,028 questionnaires. A little over half the group have a knowledge of the work of the

general rehabilitation services. Over a third of this group expressed no knowledge and almost nine percent gave no response.

Less than half knew about the services offered by the Services for the Visually Impaired. Almost half denied any specific knowledge of this segment of rehabilitation services and approximately eleven percent gave no response.

Almost half of the physicians have referred clients to the general rehabilitation services compared to less than one fourth who have made referrals to the Services for the Visually Impaired. This can be explained, in part, because of the specialized nature of the latter services as opposed to the broader spectrum of cases handled by general rehabilitation. Almost a third have not made use of general rehabilitation as compared to practically one half not using the Services for the Visually Impaired.

A little less than half of the physicians have had clients referred to them by both services. Almost one fourth have never had referrals by either rehabilitation service, over one-quarter did not answer the question.

Less than half expressed satisfactory service relationship with rehabilitation and very few persons expressed dissatisfaction with the services. Approximately half did not respond to the question.

Comments on the few open end questions varied from "too much paper work in the handling of clients" to excellent recommendations for both services. All comments will be considered in the final analysis in detail.

In summary, the physicians report will contribute additional insights that will have to be considered in the final planning. The response was excellent and reflects a growing professional interest in the rehabilitation field. Of more importance, there is indicated a potential work force of professional persons for use in committees throughout the State that should be utilized effectively and judiciously.

PHYSICAL RESTORATION RESOURCES - PERSONNEL
-PHYSICIANS-

*NAME _____ *SPECIALTY _____
*SUB-SPECIALTY _____

FILL IN
DATE OF CERTIFICATION: SPECIALTY _____ SUB-SPECIALTY _____

*PROFESSIONAL MAILING ADDRESS _____

*CITY _____ *STATE _____ *ZIP _____

RETIRED ☐ PRIVATE PRACTICE ☐ FULL TIME ☐ PART TIME-% OF TIME _____

INSTITUTIONAL _____ ☐ FULL TIME ☐ PART TIME-% OF TIME _____

(Specify)

HOSPITAL AFFILIATION _____ LOCATION _____ STAFF (S) COURTESY STAFF (CS) _____

☐ S ☐ CS

☐ S ☐ CS

*If any given information is in error, make appropriate corrections above that line.

1. Do you have a sub-specialty interest in addition to that given above?

☐ Yes

☐ No

If Yes, what is this sub-specialty interest? _____

a. Check any extended training in this area below

Residency _____ years

Post Graduate, Number of Courses _____

Fellowship _____ years

None

Other _____

(Specify)

b. Would you be interested in further Post Graduate work in this area?

☐ Yes

☐ No

2. Do you know what services to handicapped persons are offered by;

The Division of Rehabilitation Services?

☐ Yes

☐ No

The Services for the Visually Impaired?

☐ Yes

☐ No

If Yes, have clients of either service been referred to you for examination?

☐ Yes

☐ No

a. Have you referred any patients to:

Division of Rehabilitation Services?

☐ Yes

☐ No

Services for the Visually Impaired?

☐ Yes

☐ No

b. Did these services measure up to your expectations?

☐ Yes

☐ No

c. Do you have any comments or suggestions concerning either of the

Rehabilitation Services?

☐ Yes

☐ No

If Yes _____

3. Would you be interested in further information regarding committee work in
your region as well as throughout the State? ☐ Yes ☐ No

Information regarding committee objectives and structure will be provided
those indicating interest.

R E P O R T

to

THE NEBRASKA OFFICE OF STATEWIDE PLANNING

for

VOCATIONAL REHABILITATION SERVICES

by

Voyle C. Scurlock
Consultant

January 26, 1968

FOREWORD

The task of statewide planning in any area of public interest demands tremendous responsibility, effort, and courage on the part of many people. When the area of interest is that of vocational rehabilitation services however, and the task involves projecting program needs and requirements several years in advance, with the attendant social, economic, and political implications for a state as large and diversified as Nebraska, and particularly at a time of rapid change, the job assumes gigantic proportions.

The immensity and complexity of the task however, are more than matched by its urgency and importance. It is a challenge to the courage and best efforts of everyone in the state, for it has implications for every citizen.

The overall task is to determine what is required to provide and maintain an "adequate" program of vocational rehabilitation services in Nebraska by 1975, that is, a program of services that can rehabilitate all persons who become in need of services annually.

The role of the out-of-state consultant in such an undertaking is a most difficult one. His task is that of making some evaluation of present and existing services to determine current adequacy; to appraise existing resources; and perhaps to offer suggestions for increasing and strengthening services now, and in the future.

In doing this he must balance his concepts of the ideal, against the practical; and what might be best for another state, against what would be best for Nebraska. Regardless of the number of his contacts, or the number of reports he reads and digests, he can have but a limited knowledge of all the conditions and factors that must be considered in an undertaking of this magnitude. He therefore, must be cognizant at all times that he is basing his judgements and comments on fragmentary information.

CONSULTANT'S PREPARATORY ACTIVITIES

In preparation for this task the Consultant has spent a total of ten days in Nebraska, talking with key people, visiting agencies and institutions, reading reports, analyzing statistics, and discussing various problems with interested individuals. This has been extremely helpful in providing background information concerning the state and its resources, as well as the conditions and problems peculiar to Nebraska which affect rehabilitation services. Needless to say, without such background a consultant's services would be entirely without value.

A joint meeting was held with directors of the two official state programs and members of their staffs, the Division of Vocational Rehabilitation, State Department of Education, and Services for the Visually Impaired, Department of Institutions for a general discussion of the problems common to both agencies. Later the Consultant met with each of the directors individually to discuss the problems peculiar to his program. In the report that follows, these agencies will be referred to as "VRD" and "SVI", respectively.

Profitable visits were made to the Omaha Goodwill Industries; Hastings State Hospital; State Industrial School for Boys at Kearney; two county departments of Public Welfare; two district offices of VRD; and one district office of the State Employment Service.

A conference was also held with the two top officials of the Department of Institutions, Mr. Duncan, and Dr. Robert Osborne, Director, and Assistant Director, respectively. There was also a conference with Dr. Earl Wilson, Coordinator, Rehabilitation Counselor Training, University of Nebraska.

The Consultant also had a very pleasant and profitable meeting with two members of the State Senate, each of whom have a special interest in this project. They were, Senator Calista A. Hughes, Chairman of the Policy Committee for Statewide Planning for Vocational Rehabilitation Services; and Senator Richard Marvel, Chairman of the State Budget Committee.

I - THE OVERALL PICTURE: It would appear from the best information available that the backlog of disabled persons eligible and in need of rehabilitation services is constantly increasing both in Nebraska and in the Country; and that the rate of increase in Nebraska is greater than that for the Country.

1/ - Results of a 1965 estimate based on data from the National Health Survey and state rehabilitation agencies indicate:

	<u>Country</u>	<u>Nebraska</u>
Backlog (1965 Estimate)	3.6 million	28,120
Rehabilitated - 1965	134,859	806
% of backlog rehabilitated	3.6%	2.9%

2/ - The increasing backlog of persons in need of rehabilitation services is constantly increasing the already tremendous cost of dependency.

3/ - By 1970 it is estimated there will be an additional 500,000 persons in the country who will become disabled and in need of rehabilitation services each year -- or approximately 2½ to 3 persons per thousand of the general population. Applied to Nebraska, it appears the state will need to rehabilitate from 3800 to 4500 persons per year by 1975.

4/ - In order for Nebraska to have an "adequate" program by 1975 it will be necessary to expand its present services three and a half to four times its present operation.

II - PRESENT SERVICES: In spite of limited financial support it would appear the official state programs have made somewhat slow, but steady progress in recent years: -

1/ - The number of persons served per 100,000 population in Nebraska increased from 189 in 1962, to 245 in 1966. In spite of this Nebraska dropped in rank among the states from 25th to 28th during this period.

2/ - In persons rehabilitated per 100,000 population, Nebraska produced 48 in 1962, against a national average of 55; and 62 in 1966, against a national average of 78. It ranked 30th among the states both years.

3/ - Increased rehabilitations -- 1967 over 1966:

For the Country	13%
For the Region	20%
Nebraska DVR	26%
Nebraska SVI	27%

III - THE FINANCIAL PICTURE: Although Nebraska appears to compare favorably with other states in wealth, measured by per capita income, it does not compare favorably in it's support of vocational rehabilitation services.

1/ - Increase in per capita income, 1966 over 1965:

The Country	from	\$2214	to	\$2362, or 7%
Nebraska	from	2098	to	2256, or 8%

2/ - Ten-year increase in state funds for vocational rehabilitation services, 1955 - 1964:

Nebraska	135 % increase
The Country	245 % increase
Rank among the states	- 45th

3/ - Expenditures per capita for vocational rehabilitation services, 1966:

Nebraska	\$.68
National average	1.09
Rank among the states	- - 50th

IV - EFFECT AND IMPLICATIONS OF INADEQUATE SUPPORT. Inadequate financial support seems to be reflected in expenditures for VR services, and could in time tend to emphasize services to the less-seriously disabled in the interest of increased production:

1/ - Average cost per person rehabilitated, 1966:

Nebraska	\$ 1,096
National average	1,385

2/ - Average expenditure per counselor, 1966:

Nebraska	\$21,565
National average	34,449

3/ - Increased use of "third-party" agreements is directly tracable to inadequate appropriations. It has much to be said for it in terms of an "Integrated" program through which the resources of two or more agencies are "pooled" in the interest of a common objective. It can, and eventually no doubt would, result in an unbalanced program. (More will be said about this elsewhere.

It appears that in the 1968 fiscal year, 53% of the total funds, state and federal, used for VR services in Nebraska will come from "third-party" agreements.

V - THE NATURE AND CHARACTER OF PRESENT SERVICES: Available data seems to indicate that the state, for the most part, is operating a limited "traditional-type" program, concentrating on the younger, and perhaps less difficult and less expensive client to the almost complete exclusion of certain segments of the disabled and dependent population, such as the public offender, older people, the alcoholic, and those requiring the services of rehabilitation and adjustment centers, and sheltered workshops. This no doubt is due, in part, to inadequate financial support. Through the use of "third-party" agreements with other public-supported organizations dynamic new programs of services have been initiated for the mentally ill, mentally retarded, and welfare recipients, but these as yet are reaching but a token number of those in need of services.

1/ - Referral sources, 1966:

<u>Referral Source</u>	<u>Nebraska</u>	<u>Nationally</u>
Educational institutions	18.4 %	14.2 %
Hospitals	20.1 %	15.4 %
Physicians	8.4 %	13.3 %
Self-referred	10 %	11.3 %

2/ - Clients selected and served from referred status indicates quite rigid screening, and perhaps inadequate evaluation, a five-year record, 1962-1966. (Per cent accepted)

<u>Year</u>	<u>Nebraska</u>	<u>Region</u>	<u>Country</u>
1962	75 %	50 %	50 %
1963	72 %	45 %	50 %
1964	66 %	47 %	51 %
1965	77 %	50 %	50 %
1966	78 %	51 %	49 %

3/ - Age of persons rehabilitated, 1966:

<u>Age</u>	<u>Nebraska</u>	<u>Country</u>
Under 20	30.7 %	22.9 %
55 and over	9 %	10.8 %

4/ - Previous education of those rehabilitated, 1966:

<u>School years completed</u>	<u>Nebraska</u>	<u>Country</u>
8 years or less	19 %	38.4 %
13 years or more	11.9 %	6.8 %

VI - NEW COOPERATIVE PROGRAMS OF SERVICE: As indicated earlier in this report certain new programs of services have been initiated by VRD through "third-party" agreements with other public supported organizations. We should like to discuss each of these briefly as follows:

- 1/ - The "Public Assistance Project - 1963-1966, carried out jointly in Douglas and Lancaster Counties between the State Department of Public Welfare and VRD, as a pilot program "to find new and better ways to vocationally rehabilitate public-assistance clients", and thus reduce welfare rolls and the cost of dependency, is an excellent demonstration of what can be done by having two agencies pool their resources to accomplish a common objective. The report, written in 1966, indicated the possibility of expanding this cooperative program throughout the state. A careful review of the demonstration should serve as a starting point for this type of program in other counties of the state. Both agencies involved should be complimented for their interest and efforts in this connection.
- 2/ - The Hastings State Hospital is another excellent example of a good cooperative program of services. When one out of every two beds in the Country is filled with a mentally ill person, it becomes obvious that mental illness is one of the most serious problems with which we are concerned, and the mentally ill makes up one of the largest groups of the disabled, who are dependent and in need of vocational rehabilitation services.

This joint project between VRD and the Department of Institutions has been carried out as a "third-party" agreement, in which the services of both have been integrated and brought to bear on people in need of them. As any pilot program will, the new program of necessity has been forced to "learn by doing". In the beginning the "Vocational Rehabilitation Unit" was concerned primarily with long-term chronic patients, some of whom had been in the hospital for ten years or more. It is amazing what has been accomplished. If these same patients, most of whom were in and out of the hospital a number of times earlier, had had the benefit of the services of the new program eight or ten years sooner, the state doubtless would have been relieved of their support a long time ago.

Now that this program has demonstrated its effectiveness with the chronic patient it would appear that steps should be taken to bring this service to the young "short-term" patient - in all of the State's Hospitals -- so that when they leave the hospital their rehabilitation will be complete. If ways can be found to do this, a long step will have been taken toward the development of a stronger more effective program of services.

- 3/ - The Grand Island Public School Program, Jointly sponsored by VRD and the public school system of Grand Island, apparently is demonstrating what can be done to rehabilitate young people, particularly the "slow-learner" and mental retardate.

This type of program "preventive" in nature, since it identifies and serves the disabled person before he becomes more disabled through lack of skill, social adjustment, and confidence, is such that it should be developed in all of the schools of the state.

- 4/ - The State Industrial School for Boys at Kearney is at the point apparently where an excellent cooperative program might be developed for the rehabilitation of the young public offender, on a pilot basis. Such a program might eventually be extended to the state reformatory and the state penitentiary, with large potential returns to the state, both in terms of money saved, and lives directed into useful pursuits.

Such programs have already been developed in a number of states, and the state can gain much from the experience of these programs.

VRD already has a counselor assigned to the school at Kearney, but it would appear there has not been developed a comprehensive joint plan for the full integration of the services of VRD and the Department of Institutions to provide the necessary guidelines for an effective program. Such agreement or plan should take into account both the functions of security and rehabilitation, and clearly define the objectives, as well as the relationships of the two Departments in such an undertaking.

In view of the fact VRD has at its disposal in excess of \$200,000 of federal funds, which could be used during the current fiscal year if matched with state funds on a three for one basis, that is three federal dollars for each state dollar, the beginning of such a joint program apparently would depend on the State Department of Institutions being able to match a part of these funds, either in cash or services in kind.

VII - Services for the Visually Impaired: It would appear from the best data available that the backlog of persons suffering from visual defects in Nebraska, like those suffering from other disabilities, is constantly increasing due to an inadequate program.

- 1/ - Of the 10,000 persons estimated by SVI to have visual defects, it would appear that approximately one-half are age 65 or older. This would leave approximately 5,000, who might be considered as making up the backlog of those that should be considered for vocational rehabilitation services. The number rehabilitated in 1967 by SVI was 123 persons, or 2.46 % of the backlog.
- 2/ - A conservative estimate would indicate that there are 500 people in the state who become disabled and eligible for rehabilitation each year.
- 3/ - This means the services need to be expanded approximately four times the present operation to provide an "adequate" program.
- 4/ - Perhaps more emphasis should be placed on prevention, that is early identification and services. If there is not already an organized referral system whereby the public schools report persons with visual impairments, perhaps this should be given

- 5/ - The innovation and pilot program jointly underway between the Nebraska School for the Blind and SVI is a step in the direction of a more comprehensive integrated program of services that will insure continuity of services to the blind. SVI and the School for the Blind are to be complimented for this undertaking.
- 6/ - If, and when, the joint program between VRD and the State Department of Public Welfare is extended to other than the two counties in which it currently is operating, it might be well to consider including SVI in the planning to insure prompt referral and services for public assistance clients, who have visual defects.
- 7/ - Consideration should be given to the development of comprehensive evaluation services, and sheltered workshops. These are needed for the blind, as well as for persons with other types of disabilities. Perhaps VRD and SVI could work together to develop a workshop, which might provide evaluation services, which could be used by both agencies. If blind and sighted persons are to be served in the same workshop however, care should be exercised that the blind are served proportionately.
- 8/ - It would seem that consideration might be given to housing of personnel of the two agencies, VRD and SVI, in the same field offices throughout the state. Such arrangement would seem to be in the interest of a better and faster referral system, improved relationships, and economy.

VIII - Professional Career People, assuming they are well-trained, effective and dedicated constitute the very heart of any service program. Particularly is this true in vocational rehabilitation, due to the complexities and demands of the work. In a real sense the people, who plan and provide the services to disabled people, are even more important, than funds for services, as essential as is supporting funds. In view of this, every effort should be made to secure and hold well-trained, dedicated people, and to encourage them to make careers of vocational rehabilitation.

- 1/ - Although the present personnel appear to be effective and dedicated, there is evidence of rapid "turn-over", which means the agency is not realizing the potential of its staff. One individual stated that apparently VRD is serving as a "training ground" for the surrounding states. One reason for this may very well be inadequate salaries, but the real reason may lie in the fact that the agency does not have an established salary schedule, which gives some assurance for increases beyond the starting salary. We suggest this is in need of study.
- 2/ - Another factor in the rapid "turn-over" of staff may lie in the absence of a well-organized training program within the agency to develop and upgrade its personnel.
- 3/ - The new vocational rehabilitation counselor training program at the University of Nebraska offers possibilities for better trained staff in the future. This however, cannot take the place of an "in-service" training program within the agency.

IX - The Agency's Public Image Should be Improved.

- 1/ - The need for this is reflected to some extent by the lack of referrals of certain types of disabled individuals, due in part to lack of available services, which in turn may be due to inadequate financial support.
- 2/ - It is also directly reflected in the lack of adequate public support itself. In the final analysis the "burden of proof" is on the agency to interpret its services, operations, and needs in a manner that is readily understandable to persons not familiar with the rehabilitation process, including members of the state legislature.
- 3/ - The rapid turn-over in staff doubtless is a contributing factor to the present image. Although VRD appears to have a very good relationship with other public agencies, its over-all image could be strengthened by a stable staff of experienced people.

X - There is Need for More Research.

- 1/ - Long-range comprehensive planning for vocational rehabilitation services should take into account the need for an organized on-going program of research. Such a program should include demonstration and pilot programs designed to develop new, improved, and more effective methods and techniques of delivering services needed by the various segments of the disabled population. The "third-party" programs in public assistance, the Hastings State Hospital, and Grand Island Public Schools are good examples. These need to be expanded, and others initiated as part of an organized program.
- 2/ - It would appear that VRD and SVI might well consider the pooling of funds and resources in the future in support of a strong research unit.

XI - Summary. In summary it would appear that: -

- 1/ - The present program of rehabilitation services is less adequate, and less adequately financed than most of the states.
- 2/ - In spite of inadequate facilities and resources progress is being made in expansion of rehabilitation services in Nebraska.
- 3/ - This expansion is coming about through "third-party" agreements with other public supported agencies and organizations, whereby federal funds allocated to Nebraska for rehabilitation purposes can be matched through the use of "pooled" resources.

- 4/ - At least three new dynamic service programs have been started as pilot programs, and already the results are such as to indicate need for expansion of these new programs, and the initiation of new ones to attack the problems of persons in need of services that do not now exist.
- 5/ - In spite of the advantages of "third-party" agreements, such as the pooling of resources of two or more agencies to accomplish a common objective, they should not take the place of financial support at the state level. A program whose support comes from the "third-party" arrangement for more than half its operation is in danger of becoming unbalanced, providing very good services to some disabled persons, and providing none to others:
- 6/ - A disabled person in need of rehabilitation services in Nebraska, depending somewhat on his disability, place of residence, age, previous education, and rehabilitation needs, currently appears to have about one chance in three of becoming rehabilitated, and if he is a paraplegic, public offender, alcoholic, an elderly person, or is illiterate, his chances are further reduced.
- 7/ - For Nebraska to have an "adequate" program by 1975, the present statewide planning should call for expansion of present services by three to four times its present operation.
- 8/ - In view of the tremendous cost of dependency to the state at this time, due to disability and the lack of adequate rehabilitation facilities, the cost of developing and maintaining an "adequate" program of services would be an investment, which should pay very large dividends in future years.

FACT SHEET

STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

5620 Ames Avenue - Suite 104

Omaha, Nebraska 68104

Jack Hobbs, Director

Herbert Larson, Assistant Director

State Vocational Rehabilitation Services

- Rehabilitation Services are not provided by the Statewide Planning Office but by two agencies in the State of Nebraska: The Division of Rehabilitation Services, whose state office is located at 707 Lincoln Building, 1001 "O" Street, Lincoln, and the Department of Services for the Visually Impaired in the State Capitol Building. District offices are located throughout the State.
- Subject to the eligibility requirements of the State, vocational rehabilitation provides a range of services at no cost to the handicapped person, tailored to each individual's needs:
- full evaluation, including medical diagnosis, to learn the nature and degree of disability and to help evaluate the individual's work capacities
- counseling and guidance to achieve good vocational adjustment
- medical, surgical, psychiatric, and hospital care and related therapy to reduce or remove the disability
- artificial limbs and other prosthetic and orthotic devices needed to increase work ability
- training, including vocational, academic and remedial education, and prevocational and personal adjustment training
- service in comprehensive or specialized rehabilitation facilities, including workshops and adjustment centers
- maintenance and transportation during rehabilitation
- tools, equipment and licenses for work on a job or in establishing a small business
- placement in a job suited to the individual's highest physical and mental capacities and post-placement follow-up to make sure that the placement is satisfactory to the employee and the employer.

The Overall Problem

Nationally

- In 1965, an estimate based on data from the National Health Survey and the State Rehabilitation agencies indicated that there exists a backlog of 3.7 million disabled persons eligible and in need of rehabilitation services.
- In 1965, the total number of persons rehabilitated was 134,859. This is 3.6% of the estimated backlog.

By 1970 there will be an additional 500,000 persons needing rehabilitation services each year.

Statewide

- . Based on the above figures there is an estimated backlog in the State of Nebraska of 28,120 eligible and in need of rehabilitation services each year.
- . In 1965, the total number of persons rehabilitated was 806. This is 2.9% of the estimated backlog.
- . By 1970 there will be an estimated additional 3,800 persons in need of rehabilitation services each year.
- . These estimates pointedly indicate that there are insufficient funds, facilities and personnel to meet the mounting problems of rehabilitation. Nebraska total per capita expenditure on rehabilitation in 1965 was 48th in the nation. In spite of this low investment per capita, Nebraska was 30th in the nation in numbers of persons rehabilitated per 100,000 population.
- . There is a need for coordinated statewide planning to tie in and properly implement all previous studies and the present plan by the concerted effort of a central coordination committee.

Planning is essential for orderly development

- . To know with reasonable certainty the extent and types of the problem of disability within the state.
- . To know how much added personnel will be needed to handle the existing problem.
- . To know the capacity of present facilities and to what extent they are presently utilized.
- . To know the geographic distribution of facilities and services and their relative effectiveness in giving statewide coverage.
- . To eliminate the barriers to rehabilitation.
- . To establish a working plan with implementation to efficiently meet the needs of all persons eligible for rehabilitation by 1970.

To accomplish this

- . The state has been divided into fifteen regions so that each region will be able to study its own problems and analyze their particular needs.
- . Each region will have a Regional Chairman who will present the needs of his region, based on objective study, to a statewide planning board.
- . A Policy Board, consisting of sixteen people, serving at the invitation of the governor, will study problems statewide in social

- . The Statewide Planning Board will consist of the Policy Board and the fifteen Regional Chairmen. This combined board, in conjunction with the Statewide Planning staff will draw up the Nebraska Plan for Rehabilitation.
- . A large task force of citizens, working together in a unified effort, will make it possible to put into effect this comprehensive statewide plan efficiently and effectively.
- . The planning effort will conclude in 1968.

Resources for Planning

- . The backing of an ongoing program which has been in existence since 1920 when the first Vocational Rehabilitation Act was passed by Congress. This provides a ready-made structure and organization through established State and Federal rehabilitation agencies for implementation.
- . The Vocational Rehabilitation Act Amendments of 1965 signed by President Johnson on November 8, 1965, offers the means for implementation.
- . Significant provisions of the amendments, summarized below are grouped for convenient reference:

Rehabilitation Facilities

- . support for construction, alteration and initial staffing of public and private nonprofit sheltered workshops, rehabilitation centers and other rehabilitation facilities;
- . support for planning to determine a State's needs for facilities, both public and voluntary;
- . support for workshop improvement of equipment, staffing, and operations, and for training services provided in workshops and facilities including training allowances, and technical assistance to workshops; and
- . establishment of a National Policy and Performance Council to develop criteria and policies to be observed in making training services grants and to advise the Secretary on workshop improvement generally.

Services for the Disabled

- . increased Federal matching of State expenditures for basic services at the flat rate of 75 percent;
- . initial provision of vocational rehabilitation services for limited periods to determine the vocational rehabilitation potential of the disabled individual, for up to six months, and up to 18 months in the case of the mentally retarded;
- . support for special projects to expand the numbers of disabled persons vocationally rehabilitated;

- . elimination of the Federal requirement that an individual's financial need be determined before certain services are provided and
- . support for special State agency projects to develop innovative efforts to meet needs of severely disabled people.

Planning, Administration, and Training

- . support for State planning for orderly development of comprehensive public and private rehabilitation services in each State with the objective of making vocational rehabilitation services available by July 1, 1975, to all the disabled who need them;
- . appointment of a three-year National Commission on Architectural Barriers to Rehabilitation of the Handicapped; and
- . extension from two to four years of the ceiling of Federal support for training in rehabilitation field.

Rehabilitation Yields Tangible Results

- . Vocational Rehabilitation is one of the few State-Federal programs that provides a tangible return on the tax dollar.
- . For every tax dollar spent, at least five return in taxes.
- . Out of every 100 persons rehabilitated in 1965, 82 were non-wage earners.
- . In Nebraska, 113 rehabilitants were removed from the roles of dependency to a self-supporting, tax paying status during the two years ending June 30, 1965. The savings in tax dollars for this group is \$6,717 per month or \$80,604 per year. Rehabilitation is a one-time outlay of funds, the 10 year savings in this one group alone would approximate \$806,040.
- . Total earnings of 724 rehabilitants increased from \$229,580 to \$1,904,006 in Nebraska.
- . These are the tangible values of rehabilitation! Who can estimate the intangible value of self-respect and self-satisfaction to the individual?

Impact of Statewide Planning

- . All existing planning projects, as well as other projected programs will be encouraged and stimulated through joint cooperative efforts.
- . New facilities and the resultant added services made available through the successful completion of this study will ultimately benefit every disabled person in every age range.
- . Make full scale rehabilitation, as outlined in the Rehabilitation Act of 1965, a reality; providing services for every eligible candidate, including maximum self-care for the severely disabled; enable disabled housewives to return to full or part-time duties as a homemaker; to place the handicapped person in a job suited to his/her physical and mental capacities.

NEBRASKA COUNCIL OF THE BLIND

In view of the report and recommendations of the "Little Hoover Commission", it is abundantly evident that there will be extensive legislative proposals designed to effect a sweeping reorganization of State agencies and departments. It is further evident that much of this reorganization may well take the form of combining numerous smaller agencies into much larger administrative entities.

Feeling strongly that the welfare of the blind could be profoundly and adversely affected by such reorganization, the Nebraska Council of the Blind, composed of delegates from the three local and state organizations of the blind, at its regular meeting on December 2, 1968, unanimously adopts the following statement of its philosophy and position:

Historically, whenever and wherever the program for the rehabilitation of the blind has been submerged in a large, general agency, the blind have invariably suffered from inadequate and inferior service. This is so well and widely recognized that thirty-six states now maintain separate, specialized programs for the rehabilitation of their blind citizens.

While we neither affirm nor believe that this relative neglect of the blind is deliberate or intentional, history has convincingly demonstrated that it is virtually inevitable. This results primarily from the highly specialized needs and problems inherent in service to the blind, and the corresponding necessity for a staff specially trained and experienced in the rendering of this service. Another factor of profound significance is the higher cost in many instances of successfully rehabilitating a blind person. This often leads to spreading available funds to the greatest possible number of less severely handicapped individuals, with, again, a consequent and virtually inevitable neglect of the blind.

In view of the history of combined rehabilitation programs, and the fact that they have been weighed in the balance, found wanting, and abandoned by Nebraska and thirty-five other States, the Nebraska Council of the Blind strongly affirms its conviction that, under no conceivable plan of reorganization, should the rehabilitation program for the blind be submerged in any combined agency. We further affirm our conviction that the interests of the blind can be truly served only by the preservation of an independent agency with no other functions or responsibilities but to provide the best possible rehabilitation service to the blind of Nebraska.

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INGLESIDE

18 WEST 23RD STREET, KEARNEY
1701 SOUTH 17TH STREET, LINCOLN
129 NORTH 3RD STREET, NORFOLK

VR UNIT, NORFOLK STATE HOSPITAL
BOX 902, NORFOLK

1001 WOW BUILDING, OMAHA

14 WEST 17TH STREET, SCOTTSBLUFF

REPLY TO OFFICE CHECKED ABOVE

Dear

Workmen's Compensation Court records show that you were reported as having been injured in the course of your employment.

My concern as a rehabilitation representative is whether your disability is of such a degree that it prevents you from returning to normal employment at a job that you are qualified to handle.

The enclosed leaflet will give you brief information about services available to persons who are unable to find suitable employment as a result of a disability.

Please complete the enclosed questionnaire and return it. A representative of the Division of Rehabilitation will be glad to give you additional information about services available to disabled persons who find it difficult or impossible to find suitable employment because of this disability.

Sincerely yours,

H. J. W. Koester
Rehabilitation Representative

HJWK:jas
Enclosures

Place
Stamp
Here

Mr. H. J. W. Koester
Rehabilitation Representative
Workman's Compensation Court
Capitol Building
Lincoln, Nebraska 68509

STATE OF NEBRASKA

Work Injury - Employment Questionnaire

Please assist us by placing an (X) in the appropriate space at the right side of this form. Return completed form to H. J. W. Koester, Rehabilitation Representative, Workmen's Compensation Court, Capitol Building, Lincoln, Nebraska 68509.

- | | Yes | No |
|--|-----|-----|
| 1. Are you now working? | () | () |
| 2. If not yet working, do you expect to return to the same employer? | () | () |
| 3. Do you expect to return to the same type of work? | () | () |
| 4. Will it be necessary for you to change the type of work because of a disability? | () | () |
| 5. Would you like to discuss your employment problem with a rehabilitation counselor? | () | () |
| 6. Have you applied for rehabilitation services?
If so, please indicate which office: | () | () |
| <hr/> | | |
| 7. Do you plan to stop working permanently? | () | () |

Use other side for additional comments you wish to add.

Social Security Number

Signature

Telephone Number

Street or RFD Address

Date of Birth

City and Zip Code

Note: Return address appears on reverse side for your convenience.
Fold, staple, and mail.

STATE OF NEBRASKA

WORKMEN'S COMPENSATION COURT

CAPITOL BUILDING

LINCOLN, NEBRASKA 68509



NORBERT T. TIEMANN, *Governor*

BEN NOVICOFF, Presiding Judge

RICHARD N. JOHNSON, Judge

WILLIAM H. RILEY, Judge

LARRY F. WELCH, Judge

KAY PETERSON, Clerk

Phone 473-1668

H. J. W. Koester,
Rehabilitation
Representative

Re:

Dear Sirs:

Accident reports are being screened and carefully reviewed for the purpose of identifying those individuals whose extent of disability is such that vocational rehabilitation service will be necessary to enable the individual to return to productivity and if at all possible to be employed in a field appropriate for the individual and within his remaining capacities.

To enable us to identify the cases to be referred we need copies of medical reports to give us a basis on which to evaluate the extent of the permanent disability as well as the remaining potential to be developed to make suitable employment of the individual possible.

If you have physicians' reports pertaining to the individual identified above we will appreciate receiving a copy of such report or reports.

We appreciate your cooperation. The end result should benefit the individual as well as all concerned with the matter of industrial accidents.

Sincerely,

H. J. W. Koester
H. J. W. Koester,
Rehabilitation Representative

HJWK/kp

RELEASE

The undersigned is informed and understands that the State of Nebraska, Department of Services for the Blind and Partially Sighted, desires to take photographs and motion pictures of the undersigned at various times and places and to exhibit such photographs and motion pictures to the public and to private individuals for the purpose of diffusing information and arousing interest in the work of said Department for the benefit and welfare of persons who are blind or partially sighted. It is understood that such photographs and motion pictures to be exhibited will not in any way reflect on the morals and good reputation of the undersigned and will contain nothing of a derogatory nature concerning the undersigned.

In consideration of the premises, the undersigned hereby authorizes and consents to the taking of his photographs both in still and in motion pictures at any and all reasonable and proper times and places without the payment of any fee or thing of value to the undersigned, and hereby consents to the exhibition of such photographs and motion pictures to the public or to private individuals without restriction and without payment of any fee or benefit, financial or otherwise, to the undersigned. The undersigned hereby further releases The State of Nebraska, Department of Services for the Blind and Partially Sighted, from any and all liability of every nature which may hereafter occur as a result of or growing out of the taking or exhibiting of such still or motion pictures and photographs, and from any and all claims for damages arising therefrom.

It is also understood and agreed that the finished films of such photographs and motion pictures shall be and remain the property of The State of Nebraska, Department of Services for the Blind and Partially Sighted, and may be loaned, rented or sold by it to other persons, groups or agencies to be used for all proper and legitimate purposes.

Dated this _____ day of _____, 195 _____.

Witness

The above release approved and accepted this _____ day
of _____, 195 _____.

STATE OF NEBRASKA,
Department of Services for the Blind
and Partially Sighted

By _____
Director

Department of
for the Visually Impaired
Administrative Agency
Erion E. Clark, Director



Jack Hobbs, Director
Herbert J. Larson, Assistant Director

5620 Ames Avenue
Omaha, Nebraska 68104
Area Code 402 451-0302

State of Nebraska

STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

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rector Adult
Service,
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44th Avenue
braska 68105

ND C. WHIPP, Exec. Dir.
ndustries
n 41st Street
braska 68105

Dear Householder:

This letter is to introduce the bearer as a volunteer representing the Statewide Planning for Vocational Rehabilitation Services for the State of Nebraska.

As explained in a letter you recently received, we would like you to answer some questions which will help your state to plan for these vital services to the handicapped. All information given will be kept confidential.

Your address was selected at random from lists of names obtained from city directories, rural lists and other sources without any previous knowledge of who would be selected.

Thank you for helping us.

Sincerely yours,

Jack Hobbs

Jack Hobbs, Director
Statewide Planning for Vocational
Rehabilitation Services

JH/bb

ADDRESS _____
OR TOWN _____ INTERVIEWER _____

: W _____ C _____ OTHER _____ (13) TIME STARTED _____ ENDED _____ (15)
(Specify)

OF SECTIONS: CHILDREN _____ ADULTS _____ DATE _____

(GIVE YOUR INTRODUCTION ACCORDING TO INTERVIEWER INSTRUCTIONS)

How many persons usually live here?

Does this include roomers and yourself? Do not include visitors. _____

Would you give me some information about them? We are not interested in names. You may start with any one you like. (Pause) What is (his) (her) relationship to the head of the house? How old is (he) (she)? What does (he) (she) do? (Or, if school age) what grade is (he)(she) in? (Continue until all members of the household are listed.)

PERSONS IN HOUSEHOLD					
1	2	3	4	5	6
CHECK HERE*	RELATIONSHIP TO HEAD OF HOUSE	AGE	SEX	OCCUPATION OR GRADE IN SCHOOL	HANDICAPPED IDENT. NUMBER
*PERSON INTERVIEWED					

(After listing persons in household, select appropriate age range as indicated by the above list and continue with the questions below pertaining to that age range.)

a. These questions are about the child (children) too young to go to school.

(1) Is any child not able to play with other children because of a serious injury or illness of a permanent nature?

1.Yes ___ 2.No ___ 36

(2) Is any child unable to play in the same way or do as much as other children close to his age? That is, he needs special rest periods; can't play for a long period at a time or play active games.

1.Yes ___ 2.No ___ 39

- (3) Is any child hard of hearing, have a speech problem, or unable to see well enough that he may have problems in school later on. 1.Yes__2
- (4) Does any child need special medicine, shots, medical treatments or special therapy of any kind regularly? 1.Yes__2
- (5) Does any child appear to be much slower in learning to talk or walk or clearly much more awkward than other children the same age? 1.Yes__2
- (6) Does any child, unusually so for his age, over and over again have serious problems getting along with others, such as insisting on having his own way; resorting to temper tantrums; be very selfish, extremely quarrelsome, or overactive? 1.Yes__2
- (7) Does any child unusually so, compared with other children, prefer to play alone, not paying attention to others, seeming not to recognize them? 1.Yes__2

b. These questions are about the child (children) of school age or attending school.

- (1) Is any child not able to go to school or play with others because of a serious injury or illness of a permanent nature? 1.Yes__2
- (2) Does any child have to go to a special school, or have a special teacher? 1.Yes__2
- (3) Does any child go to school only part of the time or for a shorter length of time than other children the same age? 1.Yes__2
- (4) Is any child, attending school full time, limited or unable to take a part in athletics, games, or clubs, as other children of the same age? 1.Yes__2
- (5) Does any child need special medicine, shots, medical treatment or special therapy of any kind regularly? 1.Yes__2
- (6) Does any child have a serious hearing or eyesight problem that is not fully taken care of by a hearing aid or glasses, that may have an effect on his school progress? 1.Yes__2
- (7) Does any child have continued serious problems obeying school rules, teachers, or parents? 1.Yes__2
- (8) Does any child have trouble keeping up with school-work, that is, has any failed one or more courses or had to take a grade or grades over? 1.Yes__2

c. Adults

(1) Is any adult unable to do the work of a housewife; unable to work at any outside job or business or unable to leave his home because of a permanent or confining disability?

1.Yes ___ 2.No ___ 5

(2) Is any adult who is working or able to work unable to use public or private transportation without someone to assist him?

1.Yes ___ 2.No ___ 5

(3) Is any adult limited in some way from doing the same kinds and amounts of work as others the same age, such as lifting, carrying, doing household chores or other active work?

1.Yes ___ 2.No ___ 5

(4) Is any adult unable to work for long periods of time or need special aids or rest periods at work or at home?

1.Yes ___ 2.No ___ 5

(5) Is any housewife or adult who is working full time limited or unable to take part in outside activities, such as church, clubs, hobbies, civic projects, sports, games, as others the same age?

1.Yes ___ 2.No ___ 5

(6) Does any adult need special medicine, shots, medical treatments or therapy of any kind regularly?

1.Yes ___ 2.No ___ 5

(7) Does any adult have a serious hearing or eyesight problem that is not fully taken care of by a hearing aid or glasses?

1.Yes ___ 2.No ___ 5

(8) Does any physically able adult have trouble holding a steady job or is now unemployed due to problems which he seems to have a hard time in overcoming?

1.Yes ___ 2.No ___ 6

(9) Does any adult have problems over and over again with authorities in obeying rules to the extent that he has or may get into serious trouble?

1.Yes ___ 2.No ___ 6

Is there a member of this household who is away in the hospital, an institution, a special school or college?

Yes ___ No ___ 62

(IF YES:)

a. How old is he/she _____ b. Sex: _____

65

c. Relationship to head of household: _____

66

d. Where is this person? _____

68

(Name of hospital, institution, or school; location.) _____

e. For what reason or for what goal? _____

70

f. How long has this person been there? _____

g. How long is this person expected to stay there? _____

4. What do you know about the State Vocational Rehabilitation Services? _____

a. Has anyone in the household applied for services or is anyone at present a client of the State Vocational Rehabilitation Services or Services for the Visually Impaired?

Yes ___ No ___

5. What do you know about the State Employment Services? _____

a. Has anyone in the household utilized the State Employment Services?

Yes ___ No ___

(This concludes the screening interview. If there are any YES responses in Section "a" or "b" under Question 2, continue interview with Question 6 on the questionnaire for Pre-School Children and School Children. If there is a YES answer to any of the questions on Section "c" of Question 2, ask to speak to that person, if possible; then, continue with Question 17 on the Adult Interview Schedule. If there is a YES response to Section "a", Question 4, continue with the appropriate section of the questionnaire. If there is a NO answer to all "a", "b", and "c" questions, Question 2, or Section "a" of Question 4, conclude the interview with a word of thanks, such as "Thank you very much for your cooperation".

Be sure to go back to the first page of this questionnaire and verify the name and address of this household, mark the time the interview ends, and then sign your name and number. Also see that every question is answered. LEAVE NO BLANKS OR UNANSWERED QUESTIONS! If a question does not apply, please indicate this by writing in "Not Applicable" or N/A.)

INTERVIEWER COMMENTS: If you made observations in this household that seem helpful, but are not covered by questions answered, please record them here, for example: An obviously handicapped person responds but does not admit the disability, etc. If possible, tactfully attempt to obtain information concerning this person's obvious handicap.

F SERVICES HAVE BEEN UTILIZED, ASK:)

- b. Were you able to get all of these services in your home town?

Yes ___ No ___ 48

(IF NO:)

1. Which services were you not able to get in your home town? _____

49

2. Where did you have to go to get them? _____

50

3. How far is this from your home? _____

52

4. How many trips did you have to make? _____

53

5. Do you expect to have to repeat such trips in the near future?

Yes ___ No ___ 54

(IF YES:)

- a. For what purpose? _____

55

- b. How many more trips do you expect to make? _____

56

- c. Is the child still under treatment?

Yes ___ No ___ 57

(IF YES:)

1. Has he/she shown improvement?

Yes ___ No ___ 58

(IF YES:)

- a. In what way? _____

59

(IF NO:)

- b. Does your doctor expect the child to show eventual improvement?

Yes ___ No ___ 60

(IF YES:)

1. In what way? _____

61

(IF NO:)

2. Why is treatment continued? _____

62

R SCHOOL-AGE CHILDREN, CONTINUE:

- . Which school does he/she now attend?

- a. 1. Public School _____

63

2. Private School _____

(Specify school)

- b. If a Private School

1. Did he/she originally attend a Public School?

Yes ___ No ___ 65

CONFIDENTIAL

How much time has he/she lost in school due to his/her disability? _____		66
Has he/she been held back in school because of excessive absences? _____	Yes ___ No ___	67
IF YES:)		
. To what extent? _____		68
Has he/she been held back due to low grades? _____	Yes ___ No ___	69
. How would you rate his/her grades? (Question response by giving letter rating equivalent to response.)		
(1) ___ Excellent (Mainly A's)		70
(2) ___ Above Average (Mainly B's)		
(3) ___ Average (Mainly C's)		
(4) ___ Below Average (Mainly D's)		
(5) ___ Failing (Mainly F's)		
. Does he/she get much better grades in some subjects than others? _____	Yes ___ No ___	71
. Would you mind telling me which are his/her better subjects? _____		72

How would you rate his/her grades in these subjects? (Question response by giving letter rating equivalent to response.)		
(1) ___ Excellent (Mainly A's)		74
(2) ___ Above Average (Mainly B's)		
(3) ___ Average (Mainly C's)		
(4) ___ Below Average (Mainly D's)		
(5) ___ Failing (Mainly F's)		
. What subjects seem to be hardest for him/her? _____		75

. How would you rate the grades in these subjects? (Question response by giving letter rating equivalent to response.)		
(1) ___ Excellent (Mainly A's)		77
(2) ___ Above Average (Mainly B's)		
(3) ___ Average (Mainly C's)		
(4) ___ Below Average (Mainly D's)		
(5) ___ Failing (Mainly F's)		78

I am _____ with the Statewide Planning for Vocational Rehabilitation Services. A few days ago, you received a letter from our Project Office informing you that someone would call on you. Here is my letter of introduction."

This survey is important because it is one of the steps towards making rehabilitation services possible for all who need them. The answers to the questions that you give will be held in the strictest of confidence. We are interested only in the information that will help us in the total study of rehabilitation. May we have your cooperation?"

(Reason for agreement) Start with question One. Write the number of persons in the household on the space provided on the blank opposite question One. On question One, fill in columns 2, 3, 4, and 5 with the information given. Check () in column One the person giving the information. The number of people listed should agree with the number given in question One. Question Two continues with the identifying statements just below the "Persons in the Household" chart. Section "A" concerns Pre-school children; Section "b" is to be used in the event that there are school-age children in the household; Section "c" questions are for adult members.

Say to the respondent: "I am going to ask you some questions which will require only a "yes" or "no" answer. I will read them slowly so that you will be able to consider each one carefully before answering. If you do not fully understand the question I will repeat it for you."

Continue with the questions, beginning with the appropriate age range as indicated on the list of persons in the household. Read the question slowly, phrasing the statements so as to give emphasis to each important section of the question. This will give the respondent time to consider each phrase. On the children's interview follow-up questionnaire, if it will seem more comfortable to you, you may substitute the child's name in place of the pronoun. If any question within any age group is answered in the affirmative, check the appropriate response. Ask the respondent which person the response applies to. Write the number of the identifying statement in column Six on the chart opposite the person's description. If there are no "yes" responses to the identification or screening section of the questionnaire or to "Answer Question Four, close the interview with a word of thanks to the interviewee and leave. Before beginning the next interview, follow the instructions as given at the conclusion of the screening interview, making certain all blanks are filled and the heading information is completed.

If there is a "yes" response on any section of the screening interview, begin at the appropriate age level and continue the second section of the interview. Again it is important that each question is answered. If the question does not apply to the individual, write NA in the space required for the response.

Questions 10, 19 and 24 require a supplementary card which is handed to the respondent. On cards 1 and 2, read the contents of the card aloud to the interviewee. If the respondent indicates some type of assistance has been received, ask from what organization provided the service. Check the services received in the appropriate numbered column under "Kind of Assistance" opposite the agency supplying the service.

Card #3 should be checked by the respondent. This information should be recorded immediately on the interview form after the interview is terminated. Insert this card in the interview booklet.

Conclude interviews according to instructions on questionnaire.

VIEW NO. _____ PERSON INTERVIEWED: AGE _____ SEX _____

S (AGE 16 YEARS OR OVER)

What is the nature of the problem, limitation, illness, or injury? _____

18

a. How does this particularly limit your activities? _____

21

How old were you when this happened? _____ years.

23

How did you become handicapped?

a. Present at birth

b. Childhood illness/injury

c. Employment accident

d. Military injury/illness during service

e. Other illness _____

(Specify)

f. Other _____

(Specify)

25

*(Follow assigned question order, but ask starred alternates

*18 and *24 if "a" and "b" are checked)

Were you employed at the time you were injured or became sick?

Yes ___ No ___

27

(IF YES:)

a. What job did you hold when you were injured or became sick? _____

(Describe fully)

28

b. How long had you held this job when you were injured or became sick? _____

30

c. How long had you been in this line of work? _____

31

d. How long was it before you returned to work after your injury or illness? _____

32

Has your handicap interfered with or interrupted:

a. Your education?

Yes ___ No ___

33

(IF YES:)

(1) Did it result in excessive absences from school?

Yes ___ No ___

34

(2) Were you held back a grade or grades?

Yes ___ No ___

35

(3) Did it prevent you from finishing school?

Yes ___ No ___

36

b. Your employment?

Yes ___ No ___

37

(IF YES:)

(1) Did it result in excessive absences from work?

Yes ___ No ___

38

(2) Have you had difficulty obtaining jobs or maintaining a steady job?

Yes ___ No ___

39

9. Have you received any services listed on this card or any other services not listed from any public or private agencies? Yes ___ No ___ 40

(Hand Card #2 to interviewee and read list. If any service listed has been received, ask: "Did you receive any of these services from any of these agencies? Check the number of the service received under the same number opposite the supplying agency below. If none of the agencies apply, ask: "How did you obtain these services?" Write answer under other public or private agencies.)

CARD #2

- (1) ___ Medical, surgical, and/or hospital service
- (2) ___ Psychiatric Services (Including Psychotherapy)
- (3) ___ Psychological Testing
- (4) ___ Counseling and guidance
- (5) ___ Training for a job
- (6) ___ Planning for a job
- (7) ___ Assistance in finding a job
- (8) ___ Physical, speech, manual, occupational therapy
- (9) ___ Dental Services and/or Dentures
- (10) ___ Provision of artificial limb, braces, hearing aid; glasses, or other artificial appliance

a. Did you receive any of these services from any of these agencies?

(Read each agency and record responses as per instructions above)

AGENCY	KIND OF ASSISTANCE									
	None	1	2	3	4	5	6	7	8	9 10
(1) State Vocational Rehabilitation Services	___	___	___	___	___	___	___	___	___	___
(2) State Employment Service	___	___	___	___	___	___	___	___	___	___
(3) University of Nebraska Hospital Clinic	___	___	___	___	___	___	___	___	___	___
(4) Creighton Clinic	___	___	___	___	___	___	___	___	___	___
(5) Nebraska Psychiatric Institute	___	___	___	___	___	___	___	___	___	___
(6) Visiting Nurse Assn. or Public Health Nurse	___	___	___	___	___	___	___	___	___	___
(7) Private Hospital	___	___	___	___	___	___	___	___	___	___
(8) Veterans Hospital	___	___	___	___	___	___	___	___	___	___
(9) Veterans Administration (Other than Hospital)	___	___	___	___	___	___	___	___	___	___
(10) Other public or private agencies	___	___	___	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___	___	___	___
_____	___	___	___	___	___	___	___	___	___	___
(Specify Agency)	___	___	___	___	___	___	___	___	___	___

61

- | | | |
|-----|----|----|
| Yes | No | 63 |
|-----|----|----|

64

Yes	No	65
-----	----	----

66

- 67

- 69

- 70

- 71

72

alternate, *21, if handicap was caused by childhood illness
injury or was present at birth.)

What was the first job you held after the injury/illness?

74

(Describe fully)

a. How did you get this job?

76

(Check one of the alternatives only. If the interviewee states that he got the job himself, ask the additional question: "Did anyone help you in any way to get this job?" We want to make sure we learn of any help he may have had from outside sources.)

(1) ☐ Through the State Vocational Rehabilitation Services

(2) ☐ Through the State Employment Service

(3) ☐ Through a private employment agency

(4) ☐ Through a vocational counselor

(5) ☐ Through friends or relatives

(6) ☐ I returned to my former job

(7) ☐ I am self-employed

(8) ☐ I got the job myself. (Ask additional question, if this is the choice.)

(9) ☐ Other way: _____
(Specify)

b. How long was it before you returned to work after your injury or illness? _____

78

c. Did you earn more or less on this job than you earned on the job you held before your injury or illness?

79

_____ More _____ Less _____ Same

(IF MORE OR LESS:)

d. How much per week?

\$ _____

15

e. Did you change your usual line of work in any way after the illness or injury?

Yes ___ No ___

17

(Usual line of work is that type of work for which the handicapped has had the most experience and/or training)

(IF YES:)

f. What was your usual line of work? _____

(Describe fully)

18

What was your first job after leaving school? _____

(Describe fully)

19

a. How did you get this job?

21

(Check one of the alternatives only. If the interviewee states that he got the job himself, ask the additional question: "Did anyone help you in any way to get this job?" We want to make sure we learn of any help he may have had from outside sources.)

- (1) ☐ Through the State Vocational Rehabilitation Services
(2) ☐ Through the State Employment Service
(3) ☐ Youth Opportunity Center
(4) ☐ Through a private employment agency
(5) ☐ Through a vocational counselor
(6) ☐ Through friends or relatives
(7) ☐ I returned to my former job
(8) ☐ I am self-employed
(9) ☐ I got the job myself (Ask additional question if this is choice.)
(10) ☐ Other way: _____
(Specify)

Are you working now:

Yes ☐ No ☐

23

(IF YES:)

a. How many hours per week do you work? _____ hours

24

(IF LESS THAN 35 HOURS PER WEEK:)

(1) Are you looking for full-time work?

Yes ☐ No ☐

25

(IF NO:)

b. How long have you been out of work? _____

26

c. Are you looking for work now?

Yes ☐ No ☐

27

d. During the past 12 months, how many months have you been:

28

(1) Employed full time? (35 or more hours per week)

_____ months

(2) Employed part-time? (Less than 35 hours per week)

_____ months

(3) Unemployed?

_____ months

(4) Retired with some part-time employment?

_____ months

(5) Are you retired?

Yes ☐ No ☐

36

Introducing the following question, give a brief summary of information you have covered so far, such as, "We have talked the jobs you have held. Now, we want to discuss in detail present/most recent job. Please answer all of the following questions on the basis of, "If YES to question 22, "your present or if NO to question 22, "the last job you held."

What is the name of your present or most recent job?

a. What are your duties? _____

b. What is the name of your employer? _____

(Complete name of company)

c. Type of business or industry: _____

d. Number of hours worked per week: _____ hours.

e. Date job started: _____
(Month) (Year)

(IF MOST RECENT JOB:)

Date job ended: _____
(Month) (Year)

f. Do/did you like the activities you do/did on this job? Yes ___ No ___

g. Do/did you like the kind of treatment you receive/
received? Yes ___ No ___

h. What do/did you like or dislike? _____

i. About how much money do/did you usually earn a week on
this job?

- | | | |
|-------------------------|------------------------|------------------------|
| (1) ___ Less than \$20. | (6) ___ \$ 60 - \$ 69 | (11) ___ \$110-\$119 |
| (2) ___ \$20 - \$29 | (7) ___ \$ 70 - \$ 79 | (12) ___ \$120-\$129 |
| (3) ___ \$30 - \$39 | (8) ___ \$ 80 - \$ 89 | (13) ___ \$130-\$139 |
| (4) ___ \$40 - \$49 | (9) ___ \$ 90 - \$ 99 | (14) ___ \$140-\$149 |
| (5) ___ \$50 - \$59 | (10) ___ \$100 - \$109 | (15) ___ \$150 or more |

What are your present sources of income or support?

(Hand Card #3 to interviewee)

Check as many as apply to you.

37

39

41

44

46

47

49

50

51

53

- (1) Wages
- (2) Wife's earnings
- (3) Earnings of other family member
- (4) Veterans pension (includes disability compensation)
- (5) Private insurance and/or company pension
- (6) Social Security
- (7) Unemployment compensation
- (8) Workman's compensation
- (9) Rent and/or interest
- 10) Private agency assistance
- 11) Public agency assistance _____
(Specify)
- 12) Other: _____
(Specify)

55

56

57

58

60

63

65

66

67

69

70

• Business college: _____
(Specify)

c. Correspondence school: _____
(Specify)

d. Other: _____
(Specify)

e. Did you complete the training? Yes ___ No ___
(IF NO:)

f. Are you still in training? Yes ___ No ___

g. In addition to all the information obtained, we would like
your ideas about services to handicapped individuals: _____

h. Is there anyone else in the household who should be inter-
viewed who has ever had a disabling illness, injury, or
mental problem of any kind? Yes ___ No ___

(IF YES, fill out another adult or child interview schedule
for that person as well as any other person identified on the
Identification Section on the Questionnaire. If the person
identified on Question 32 was not previously identified, place
a check mark opposite his name on the chart on Page 1. Also be
sure to use the same Code Number as appears on the first page of
the Questionnaire.

If no one else is to be interviewed, complete your interview with a
word of thanks, such as, "Thank you very much for your coope-
ration."

Be sure to go back to the first page of this questionnaire and
fill in the address of this household, the time the final
interview ended, and then sign your name.

Also, check to see that every question that is applicable to
the handicapped person has been answered. LEAVE NO BLANK OR
UNANSWERED QUESTIONS! If a question does not apply to the
handicapped person being discussed, please indicate this by
writing in the words "Not Applicable" or "N/A".)

72

74

75

76

78

INTRODUCTION -- GENERAL INSTRUCTIONS

Questionnaire is designed to identify persons with chronic conditions of disability. In order to construct a practical Identification questionnaire it was necessary to establish a suitable working definition for the term disability or handicap. A decision was made to accept as a premise that a disability is a medical term used to describe any temporary or long-term reduction of a person's activities as a result of an acute or chronic condition.

In the context of this research and census, we are primarily interested in the chronic (long-term or permanent) conditions of disability. An example of an acute condition would be a simple appendectomy or a broken arm which would heal normally and cause no long term problem. A chronic condition may be defined as any type of physical or mental problem that would limit a person's activity to the home, going away from work, or from participating in activities outside of work. Mental problems often are associated with vocational maladjustment in that the person may have difficulty in maintaining steady employment or they may be made manifest in behavioral problems involving persons representing authority as well as in other areas of behavior.

The questionnaire is divided into two divisions. The first division or the Identification Questionnaire consists of three sections. The first section is introductory in which the interviewer introduces himself and briefly explains the general purpose of the survey and requests the respondents cooperation. He also assures the respondent that all answers given will be held in strictest confidence.

After this brief introduction, he then asks the respondent how many persons regularly live in the house including roomers or other persons other than the immediate family. These are then listed as per the instructions on the interview form.

The second section of the questionnaire contains the identification questions. These are divided according to three age levels, beginning with the pre-school child, the school age child and adult. The interviewer will know where to begin asking questions by checking the ages recorded in the list in section one.

There are no affirmative responses in section "a", "b", or "c" of the questionnaire or to section "a" of question 4, close interview according to instructions on the questionnaire. If there is an affirmative answer in any of these sections, proceed to the second division according to the instructions following question 5.

Following are a few basic rules which must be adhered to:

Follow the stated wording in the questionnaire exactly as written. If anyone asks you to explain, read the question again using the same wording. DO NOT paraphrase!!!

Read the question slowly enough so the respondent can grasp the meaning of the question readily.

Be sure to fill out the heading completely with reference to time when the interview started or ended.

Keep a record of your travel time and mileage between interviews.

Be patient and courteous but firm in keeping the interviewee on the subject. Do not irritate the interviewee and do not show any annoyance on your part. Remember, you are his guest and he is doing you a favor in responding to your questioning.

Always thank the interviewee at the conclusion of the interview and make a verbal comment on courtesies shown.



IMPORTANT INSTRUCTIONS

-Read Carefully-

ALL INTERVIEWERS

This is your Interviewer Kit. In this kit you will find the following:

1. General Instructions for interviewers and an Introduction to the Survey form.
2. A letter of introduction to the householder.
3. Two copies of the Interviewer's Daily Report.
4. In some areas lists will be inserted in kits and, for rural interviewers, plats of Townships when available.
5. Card #1 and Card #2 to be used with questions 10 in the Children's Schedule (page 5 and question 19 in Adult Schedule (page 10)).

Each interviewer will be supplied with one complete Questionnaire form for every householder on his list. In many households there will be no handicapped persons identified. This will provide the interviewer with additional Child and Adult sections. These surplus follow-up Child and Adult Interview Schedules can be used with other households where there are multiple identification of handicapped persons. If, in a rare case, the interviewer should happen to use up the surplus sections, he should contact the County Chairman for additional copies. There should be one schedule filled out for every handicapped person identified. A few extra forms will be provided to the County Chairman. Usually other interviewers who have completed their surveys will have filled in unused second and third sections with their kits.

Each interviewer fills out the Interviewer's Daily Report form with Interview Number and Name of Household at the time of the receipt of their list of calls. The Interview Number is the number assigned to the Identification Section of the questionnaire and is located at the upper right hand corner. At the same time enter the name and address on the questionnaire to assure that the number on the questionnaire agrees with the number assigned to that name on the Interviewer's Report form. If a handicapped person is identified in that household, this same Interview Number should be entered on subsequent additional forms of the Children and Adult Interview Schedules. It is extremely important that this is done at the time of interview since this number is our only method of identifying the follow-up Questionnaires with the Identification Questionnaire.

After every call the interviewer should check the appropriate column following the name of the Householder as to whether the householder listed was interviewed, not home and requires a back call or if the house is vacant.



If back calls have to be made, these should be listed below the original listing on the Interviewer's Daily Report form and called upon the next day or as soon as possible. It may be necessary to use the second Interviewer's Daily Report form to list subsequent calls. The interviewer follows the same procedure as outlined above for the first daily report and fills in the balance of the required information. This will make it possible for the project office to check the original name and enter the new one on the master list in its place.

If there is no one living in the household listed, the interviewer should then mark on the questionnaire, above the householders name, the word "Vacant". He should also check this column on the "Interviewer Report Form" following the householders name. He will not have to concern himself about this household any further.

The County Chairman checks all material, questionnaires and forms to see that they are properly completed and delivers these kits to the Regional Chairman. It is imperative that all supporting Questionnaire forms (children and adult) bear the same number that is printed on the Identification Questionnaire.

In checking the kits before turning them over to your Chairman, make certain that the above instructions have been followed out. Note particularly if questions 10 and 19 have been correctly checked with regard to "Kinds of assistance" opposite the agency utilized.

Question 23, section "i", and Question 24 are duplicated on a separate sheet in order that the person interviewed may check these items himself, if he so prefers. Double check to see that the information checked on these sheets are entered into the questionnaire form accurately.

Question 29 - the proper grade level is circled. The college level should be circled as follows:

- 13 - Freshman
- 14 - Sophomore
- 15 - Junior
- 16 - Senior
- 17 - Bachelors Degree completed
- 18 - Doing graduate work beyond
Bachelors level
- 19 - Masters Degrees
- 20 - Doctorate

There are two typographical errors of consequence. In the concluding instruction on the Identification Questionnaire, page #4 the sentence "If there is a YES answer to any of the questions on Section 'c' of Question 15, ask to speak to that person, if possible; then, continue with Question 17 in the Adult Interview Schedule", should read Question 15 in place of 17. The footnote on Question 17, page 9 gives the starred alternates as *18 and *22. These should be *18 and *21.

If the interviewer wishes to make any comments of any kind that may help to clarify any response or situation, he should feel free to write these comments on the questionnaire form. When he is in doubt as to the appropriateness of the information received, he should comment about this as well.

We want to thank you for your assistance in carrying out this project to completion. The information we gather will be helpful in preparing the future plans for expanding rehabilitation services. We are sure you will be anxious to hear about the results and look forward to the Feed-back meeting which will be conducted in your Region following the completion of the figures. Everyone will be invited to participate in this meeting so they will be able to evaluate



14416

TOTAL MILES FOR DAY

MILLIE AGF

TIME

[[[SINT]]]

TOTAL

ISTINIA

TOTAL.

ADDRESS

INTERVIEW
COMPLETED

NO ONE
HOME

UNWILLING TO
ANSWER QUESTIONS

1.

2.

3.

44.

5.

• 9

7.

3.

6.

三

1

2.

3.

24.

5.

9.

2.

3.

En

1

1

2

3



DIRECTORY INFORMATION FORM

FACILITIES AND AGENCIES

Identification Number _____

Agency or Facility _____

15 - 17

Number _____ Street _____ City _____ County _____

Administrative Officer _____

Name _____ Title _____

18 - 20

Name and Title of Person Interviewed or Completing Questionnaire. _____

Name _____ Title _____

21 - 23

_____ (1) Personal Interview

_____ (2) Mail Questionnaire

24

Sponsor _____

Public _____

25 - 26

_____ (1) National

_____ (2) State

_____ (3) County

_____ (4) City

Church _____

_____ (5) Catholic

_____ (6) Protestant _____

_____ (7) Jewish (Specify Denomination) _____

Private-Non Profit or Profit Making _____

_____ (8) Community Non-Profit

_____ (9) Fraternal Order

_____ (10) Private Profit Making

_____ (11) Other Non-Profit _____

(Specify)

Proprietorship _____

_____ (1) Individual

_____ (2) Partnership

_____ (3) Corporation

_____ (4) Other Proprietary _____

(Specify)

27

Date Established _____

28 - 29

Our organization services are limited to persons who live in the:

_____ (1) City only

_____ (2) County

_____ (3) County and Surrounding counties

_____ (4) Entire State and beyond

30

9. Is Rehabilitation a primary purpose of your facility or agency?

_____ (1) Yes _____ (2) No

10. Does your organization require licensing or certification?

_____ (1) Yes _____ (2) No

If Yes:

a. Is your organization presently certified or licensed?

_____ (1) Yes

_____ (2) No

_____ (3) Provisionally

If (2) No or (3) Provisionally is checked:

1. Check Below all certification barriers

_____ (1) No barriers - conditions fulfilled,
awaiting re-exam.

_____ (2) Requisite qualified Professional Personnel
not available.

_____ (3) Present facilities inadequate to meet
requirements.

_____ (4) Present equipment inadequate to meet
requirements.

_____ (5) Lack of adequate finances to make necessary
changes or additions

_____ (6) Other _____
(Specify)

11. Is your facility or agency presently able to meet all demands for services in all areas of competency without turning clients or patients away?

_____ (1) Yes _____ (2) No

If Yes:

a. How many clients or patients did you service in
the past year? _____

If No:

a. How many patients or clients were you unable to service in
the past year? _____

b. Were there any specific types of disabilities or clients
that you were unable to serve? _____

c. Was this due to (check all that apply):

_____ (1) Lack of Space

_____ (2) Lack of Personnel

_____ (3) Lack of Proper Equipment

_____ (4) Lack of Adequate Financing

_____ (5) Service too large an area

_____ (6) Unable to obtain all needed services in local
area

_____ (7) Other _____
(Specify)

Do you have a waiting list for your services?

_____ (1) Yes _____ (2) No

If Yes:

a. How many persons are usually on your waiting list? _____

b. What is the average waiting period for services?

_____ (1) 1 - 7 days

_____ (2) 8 - 15 days

_____ (3) 15 - 30 days

_____ (4) 1 month to 2 months

_____ (5) 2 months to 6 months

_____ (6) Over 6 months

c. Are waiting periods due to (Check all that apply):

_____ (1) Lack of Space

_____ (2) Lack of Personnel

_____ (3) Lack of Proper Equipment

_____ (4) Lack of Adequate Financing

_____ (5) Service too large an area

_____ (6) Unable to obtain all needed services in local area _____

(Specify)

_____ (7) Other _____

(Specify)

Present Facilities or Housing

Do you:

_____ (1) Rent or Lease

_____ (2) Own

_____ (3) Have free use?

The facilities:

_____ (1) Were originally constructed to fulfill our needs.

_____ (2) Were adapted or remodeled to fulfill our needs

_____ (3) Required no adaptation for initial use

The facilities are:

_____ (1) Adequate for immediate and future needs

_____ (2) Inadequate to meet future needs

_____ (3) Inadequate to meet present demands

a. If (2) or (3) are checked

Present facilities

_____ (1) Can be remodeled to meet present or future needs

_____ (2) Can be extended to meet present or future needs

_____ (3) Can be enlarged by construction of added buildings

_____ (4) Cannot be extended, remodeled or enlarged at present site.

If the response to 13a 4 is checked or for some other reason a new location is contemplated (Check appropriate response)

- ☐ (1) We are looking for a new site.
- ☐ (2) We have a new site under consideration.
- ☐ (3) We have an option on a new site.
- ☐ (4) We have purchased a new site.

We are now engaged in a building fund drive.

- ☐ (1) Yes ☐ (2) No

We have made application for construction funds through:

- ☐ (5) Government Grant
- ☐ (6) Philanthropic Organizations (Specify type)
- ☐ (7) Our own parent organization.
- ☐ (8) Through Private banking or financing channels.
- ☐ (9) Private Donors or Charities
- ☐ (10) Other (Specify)

We have been granted new construction funds through:

- ☐ (11) Government Grant
- ☐ (12) Philanthropic Organization (Specify type)
- ☐ (13) Our own parent organization
- ☐ (14) Through private banking or financing channels
- ☐ (15) Private Donations or Charities
- ☐ (16) Other (Specify)

We need assistance from Statewide Planning to discuss:

- ☐ (17) Planning to meet the basic needs of the area served.
- ☐ (18) The feasibility of expansion.
- ☐ (19) Coordination with other services.
- ☐ (20) Other (Specify)

4. Is there any delay beyond usual waiting period in providing service to clients once they have been referred due to eligibility requirements? ☐ (1) Yes ☐ (2) No

If Yes:

a. How long do clients or patients generally have to wait before eligibility is established?

- ☐ (1) 1 - 7 days
- ☐ (2) 8 - 14 days
- ☐ (3) 14 - 30 days
- ☐ (4) 1 month to 2 months
- ☐ (5) 2 months to 6 months
- ☐ (6) 6 months and over

b. What factors usually delay establishment of eligibility?
(Check items that most frequently apply)

<input type="checkbox"/>	(1) Data from referral source	
<input type="checkbox"/>	(2) Medical reports	
<input type="checkbox"/>	(3) Psychological reports	<input type="checkbox"/>
<input type="checkbox"/>	(4) School records	69
<input type="checkbox"/>	(5) Laboratory reports	
<input type="checkbox"/>	(6) Social Service records	<input type="checkbox"/>
<input type="checkbox"/>	(7) Excessive clerical work	70
<input type="checkbox"/>	(8) Central office delays	
<input type="checkbox"/>	(9) Other _____	<input type="checkbox"/>
	(Specify)	71 - 72

Manpower Requirements.

Below are listed staff positions which may be similar to those of the personnel in your facility or agency. In the first column after each position list the number allowed for in the present budget. In the second column list the number of budgeted unfilled positions at the present time. In the third column list the anticipated number you will need by 1975.

	<u>Number Budgeted</u>	<u>Budgeted Unfilled</u>	<u>Anticipated Need 1975</u>
Director	73	74	75
Administrative Personnel	76 - 77	15 - 16	17 - 18
Administrative Personnel	19 - 20 - 21	22 - 23 - 24	25 - 26 - 27
	28 - 29 - 30	31 - 32 - 33	34 - 35 - 36
Aides and Orderlies	37 - 38 - 39	40 - 41 - 42	43 - 44 - 45
Practical	46 - 47 - 48	49 - 50 - 51	52 - 53 - 54
Occupational Therapy (Registered)	55	56	57
Therapists	58	59	60
Physical Therapists (Registered)	61	62	63
Physical and Occupational Therapy Aides	64 - 65	66 - 67	68 - 69
Physicians	70 - 71 - 72	73 - 74 - 75	76 - 77 - 78
Psychiatrists	15 - 16	17 - 18	19 - 20
Psychologists	21	22	23
Rehabilitation Counselors	24 - 25	26 - 27	28 - 29
Rehabilitation Counselor Aides	30 - 31	32 - 33	34 - 35
Support Staff			

	<u>Number Employed</u>	<u>Present Need</u>	<u>Anticipat Need</u>
Social Workers	<u>42</u>	<u>43</u>	<u>44</u>
Speech Therapists	<u>45 - 46</u>	<u>47 - 48</u>	<u>49 - 50</u>
Teaching Staff	<u>51 - 53</u>	<u>54 - 56</u>	<u>57 - 59</u>
Vocational Counselors	<u>60</u>	<u>61</u>	<u>62</u>
Other _____ (Specify)	<u>63</u>	<u>64</u>	<u>65</u>

6. Type of Facility or Agency (Check as many as apply)

- _____ (1) Acute Medical Care Center 66
- _____ (2) Adoption or Child Placement Service
- _____ (3) Anti-Poverty Program
- _____ (4) Chronic Medical Care Center 67
- _____ (5) Correctional Facility
- _____ (6) College or University
- _____ (7) Day Care Service 68
- _____ (8) Elementary Education
- _____ (9) Employment Service
- _____ (10) Extended Care Facility 69
- _____ (11) Family and Child Services
- _____ (12) Halfway House
- _____ (13) Health Information Services 70
- _____ (14) Hospital
- _____ (15) Housing Service
- _____ (16) Lodging 71
- _____ (17) Medical Clinic
- _____ (18) Mental Health and/or Psychiatric Services (Acute and Short Term)
- _____ (19) Mental Health and/or Psychiatric Services (Chronic, Long Term
Care) 72
- _____ (20) Mentally Retarded, Services for (Short Term)
- _____ (21) Mentally Retarded, Services for (Long Term Care)
- _____ (22) Nursing Home 73
- _____ (23) Placement and Job Information Services
- _____ (24) Prosthetic and Orthotic Service
- _____ (25) Private Welfare Assistance 74
- _____ (26) Public Health Agency
- _____ (27) Public Welfare Agency
- _____ (28) Recreational Facility 75
- _____ (29) Research

<u> </u>	(30) Secondary Education	
<u> </u>	(31) Schools, Special Education and Training	<u>76</u>
<u> </u>	(32) Sheltered Workshop	
<u> </u>	(33) Social Service Agency	
<u> </u>	(34) Veterans Service Organization	<u>77</u>
<u> </u>	(35) Visiting Nurses Association	
<u> </u>	(36) Vocational Education or Training Center	
<u> </u>	(37) Vocational Rehabilitation Agency	<u>78</u>
<u> </u>	(38) Vocational Rehabilitation Center	
<u> </u>	(39) Other _____	
	_____	<u>15</u>

. Disabilities Serviced (Check as many as apply)

<u> </u>	(1) All Disabilities (as listed below)	<u>16</u>
<u> </u>	(2) Alcoholism	
<u> </u>	(3) Amputees	
<u> </u>	(4) Birth Defects	<u>17</u>
<u> </u>	(5) Cancer	
<u> </u>	(6) Cardiac and Circulatory	
<u> </u>	(7) Dental Problems (Malocclusion, Oral Surgery)	<u>18</u>
<u> </u>	(8) Drug Addiction	
<u> </u>	(9) Educational Deprivation	
<u> </u>	(10) Gastro-Intestinal	
<u> </u>	(11) Hearing Impairments	<u>19</u>
<u> </u>	(12) Mental Illness	
<u> </u>	(13) Mental Retardation	
<u> </u>	(14) Neurological Disorders _____	<u>20</u>
	(Specify)	
<u> </u>	(15) Orthopedic Impairments - No amputations	
<u> </u>	(16) Respiratory Diseases	
<u> </u>	(17) Skin and Allergy	<u>21</u>
<u> </u>	(18) Social Disorders	
<u> </u>	(19) Speech Impairment	
<u> </u>	(20) Visual Disorders	<u>22</u>
<u> </u>	(21) Other _____	<u>23</u>
	(Specify)	

. Service restrictions and primary characteristics of the group serviced by your organization.

Special Instructions:

Step 1 - In the numbered columns preceding the items listed below, circle number 1 for any service requirement necessary to qualify a

Step 2 - Circle number 2, preceding the item below, the particular group or groups that are most frequently served, to the best of your knowledge, by your organization.

Step 3 - Circle number 3 to denote areas which you feel could be economically and adequately serviced by your organization in addition to those you already serve through the expansion of your facilities.

A. - Age Range as related to the education level.

1	2	3	All age ranges	24
1	2	3	Pre School or 1 to 5 years	25
1	2	3	Grade School or 5 to 13 years	26
1	2	3	Secondary School or 14 to 18 years	27
1	2	3	Ungraded School children or 5 to 18 years	28
1	2	3	High School graduate	29
1	2	3	Adult, 16 years or over, not attending school	30
1	2	3	Over 65 or retired	31

B. - Population Serviced

1	2	3	All Veterans	32
1	2	3	Foreign Service Veterans Only	33
1	2	3	All ethnic groups	34
1	2	3	White	35
1	2	3	Negro	36
1	2	3	Indian	37
1	2	3	Spanish speaking (Mexican, Puerto Rican, Cuban)	38
1	2	3	Other Ethnic Groups _____ (Specify)	39
1	2	3	All Religious Groups	40
1	2	3	Protestant _____ (Specify)	41
1	2	3	Catholic _____ (Specify)	42
1	2	3	Jewish	43
1	2	3	Other Religious Groups _____ (Specify)	44
				45

C. - Major Income Group Served

1	2	3	All Income Groups	46
1	2	3	Under \$3,300 per year	47
1	2	3	\$3,300 to \$5,000 per year	48
1	2	3	\$5,000 to \$7,000 per year	49
1	2	3	\$7,000 to \$10,000 per year	50
1	2	3	Over \$10,000	51

D. - Gender

1	2	3	Male	52
1	2	3	Female	53
1	2	3	Both	54

E. - Establishment of Residence

1	2	3	None	55
1	2	3	Three months and over	56
1	2	3	Six months and over	57
1	2	3	One year and over	58

Referral Sources

Special Instructions:

Circle 1, preceding the item listed below to denote the sources from which referrals will be accepted.

Circle 2, to denote to the best of your knowledge, the largest sources of referral to your organization.

1	2	Any of the below	59
1	2	Anti-Poverty Programs	60
1	2	Church and Religious Organizations	61
1	2	Correctional Institutions	62
1	2	Division of Rehabilitation Services	63
1	2	Educational Institutions	64
1	2	Health Service Organizations	65
1	2	Hospitals and Clinics	66
1	2	Insurance Companies	67
1	2	Interested Persons	68
1	2	Physicians	69
1	2	Relatives	70
1	2	Selective Service	71
1	2	Self	72
1	2	Services for the Visually Impaired	73
1	2	Social Security Administration	74
1	2	State Employment Services	75
1	2	Unemployment Compensation Offices	76
1	2	Welfare Services	77
1	2	Other _____	78
		(Specify)	

Listed below are a number of services that are frequently provided for or to disadvantaged, physically, mentally, emotionally or otherwise handicapped persons. Circle only those items that apply to your organization according to the special instructions below.

Special Instructions:

Circle 1, preceding each item listed below, the items of service provided directly by your organization.

Circle 2, preceding each item listed below, the items of service not provided directly by you but are purchased or provided by means of referral to your client from an outside source of supply.

Circle 3, the items or areas you have definite plans to develop, expand or add to the current list of services you extend to your patients or clients before 1975.

A. - Family and Child Services and Child Welfare

1	2	3	Adoption Services	15
1	2	3	Child Services	16
1	2	3	Casework Counseling	17
1	2	3	Crippled Children's Services Program	18
1	2	3	Day Care Services	19
1	2	3	Family Counseling	20
1	2	3	Financial Planning	21
1	2	3	Homemaker Services	22
1	2	3	Home Visits by Public Health Nurses	23
1	2	3	Housekeeper Service	24
1	2	3	Housing for the Aged	25
1	2	3	Housing for those with special disabilities	26
1	2	3	Legal Services	27
1	2	3	Pre-School Nursery Care	28
1	2	3	Protective Services for Children	29
1	2	3	Recreational Services	30
1	2	3	Well Child and/or Pediatric Clinic	31
1	2	3	Other _____	32
(Specify)				

B. - Financial Assistance to Families (Public and Private)

1	2	3	Aid to Blind	33
1	2	3	Aid to Disabled	34
1	2	3	Aid to Families with Dependent Children	35
1	2	3	General Assistance	36
1	2	3	Financial Assistance (Other than the above)	37
1	2	3	Medical Assistance	38
1	2	3	Medicaid Title XIX	39
1	2	3	Training Subsistence or Allowance	40
1	2	3	Other _____	41
(Specify)				

C. - Health Service (In Patient and Out Patient-Physical)

1	2	3	Audiology	41
1	2	3	Dental Clinic	42
1	2	3	Dystocia Clinic	43
1	2	3	Health Information	44
1	2	3	Maternity Clinic	45
1	2	3	Medical Care for the Acutely Ill	46
1	2	3	Medical Care for the Aged	47
1	2	3	Medical Care for the Children	48
1	2	3	Medical Care for the Chronically Ill	49
1	2	3	Medical Social Service	50
1	2	3	Mobility Instructions	51
1	2	3	Neurological Evaluation	52
1	2	3	Nursing Services (Home Care)	53
1	2	3	Nursing Services (In-Patient Care)	54
1	2	3	Occupational Therapy for Physically Disabled	55
1	2	3	Orthopedic Services	56
1	2	3	Orthotics and Prosthetics	57
1	2	3	Ophthalmology	58
1	2	3	Optical Services	59
1	2	3	Physical and Medical Evaluation	60
1	2	3	Physical Therapy	61
1	2	3	Other _____	62
			(Specify)	63

D. - Health Services (Mental Health-In Patient Services)

1	2	3	Group Psychotherapy	64
1	2	3	Nursing Services	65
1	2	3	Occupational Therapy for Mental Patients	66
1	2	3	Psychiatric Evaluation	67
1	2	3	Psychiatric Social Service	68
1	2	3	Psychiatric Treatment	69
1	2	3	Psychological Evaluation (Clinical)	70
1	2	3	Therapeutic Recreation	71
1	2	3	Other _____	72
			(Specify)	73

E. - Health Service (Mental Health-Out Patient Services)

1	2	3	After Care Services	74
1	2	3	Mental Health Clinic	75
1	2	3	Mental Health Information	76

Health Service - Cont'd.

1	2	3	Psychiatric Treatment Center	77
1	2	3	Psychotherapy (Group)	78
1	2	3	Psychotherapy (Individual)	15
1	2	3	Other _____	16
			(Specify)	17

F. - Vocational Services and Education

1	2	3	Job Engineering	18
1	2	3	Job Placement and Follow-up	19
1	2	3	Psychological Testing (Vocational)	20
1	2	3	Sheltered Workshop	21
1	2	3	Vocational Guidance and Counseling	22
1	2	3	Vocational Training	23
1	2	3	Work Adjustment	24
1	2	3	Work Evaluation	25
1	2	3	Basic Education	26
1	2	3	Secondary Education	27
1	2	3	Other _____	28
			(Specify)	29

G. - Correction

1	2	3	Court Social Service (Adult)	30
1	2	3	Court Social Service (Juvenile)	31
1	2	3	Probation Counseling and Services	32
1	2	3	Protective After Care	33
1	2	3	Prison Social Service	34
1	2	3	Juvenile Offender Social Service	35
1	2	3	Uther _____	36
			(Specify)	37

21. Do you have an In-Service Training Program for your professional and administrative staff?

_____ (1) Yes _____ (2) No

If Yes:

a. Is there a pre-service orientation and training program that precedes the first duty assignment?

_____ (1) Yes _____ (2) No

If Yes:

1. How much time is allotted for pre-service orientation and training?

_____ (1) 1 day

- _____ (2) 1 to 7 days
- _____ (3) 1 to 2 weeks
- _____ (4) 2 to 4 weeks
- _____ (5) 1 month to 2 months
- _____ (6) 2 months to 6 months
- _____ (7) 6 months and over

b. Is there an opportunity to work with other individuals assigned to similar work in other areas than assigned to the employee?

_____ (1) Yes _____ (2) No

41

c. Are there in-service programs to familiarize the employee with procedures performed by others whose work will directly effect his production?

_____ (1) Yes _____ (2) No

42

d. Is the in-service program primarily limited to the locality in which the employee is going to be working?

_____ (1) Yes _____ (2) No

43

e. Are there opportunities for in-service programs in cooperation with other agencies?

_____ (1) Yes _____ (2) No

44

f. Are there special staff programs concerning the rehabilitation of the handicapped?

_____ (1) Yes _____ (2) No

45

g. Are there special stipends and/or released time for staff to obtain an undergraduate degree?

_____ (1) Yes _____ (2) No

46

A graduate degree pertaining to rehabilitation?

_____ (1) Yes _____ (2) No

47

h. Other efforts in in-service training (Check all that apply)

_____ (1) Motion Pictures

48

_____ (2) Special Speakers

_____ (3) Conferences, local

_____ (4) Conferences, out of state

49

_____ (5) Research Project

_____ (6) Other _____

(Specify)

50

22. Do you utilize disabled persons in any capacity (Check as many apply)

_____ (1) Office personnel

51

_____ (2) Maintenance Staff

- _____ (3) Professional personnel
 _____ (4) Volunteer Services
 _____ (5) Other _____
 (Specify)

52

3. Does your agency or facility receive information directly from the Division of Rehabilitation Services (DRS) and Services for the Visually Impaired (SVI) about its program?

From DRS _____ (1) Yes _____ (2) No

From SVI _____ (1) Yes _____ (2) No

53

54

4. Has your agency made referrals to DRS and/or SVI in the past year.

To DRS _____ (1) Yes _____ (2) No

To SVI _____ (1) Yes _____ (2) No

55

56

If Yes:

a. How many to DRS _____

b. How many to SVI _____

57 - 58

59 - 60

5. Do you anticipate this number of referrals to be expanded in the next year?

_____ (1) Yes _____ (2) No

If Yes:

a. How many more to DRS _____

b. How many more to SVI _____

62 - 63

64 - 65

6. Do you receive reports from DRS and SVI with regard to the disposition of the clients you refer?

From DRS _____ (1) Yes _____ (2) No

From SVI _____ (1) Yes _____ (2) No

66

67

7. Do you feel that the reports that you receive are adequate?

From DRS _____ (1) Yes _____ (2) No

From SVI _____ (1) Yes _____ (2) No

68

69

8. Do you feel that these reports can be improved?

From DRS _____ (1) Yes _____ (2) No

From SVI _____ (1) Yes _____ (2) No

70

71

If Yes:

a. In what way? _____

72 - 73

9. During the past year have you received referrals from DRS or SVI?

From DRS _____ (1) Yes _____ (2) No

From SVI _____ (1) Yes _____ (2) No

74

75

9. - Cont'd.

If Yes:

a. How many from DRS? _____

76 - 77

b. How many from SVI? _____

15 - 16

10. Does a DRS or SVI Counselor visit your facility or agency regularly?

From DRS _____ (1) Yes _____ (2) No

17

From SVI _____ (1) Yes _____ (2) No

18

If No:

a. Would it be helpful or of value to your agency or facility?

From DRS _____ (1) Yes _____ (2) No

19

From SVI _____ (1) Yes _____ (2) No

20

11. Does the DRS or SVI have any specific cooperative agreements with your facility or agency?

With DRS _____ (1) Yes _____ (2) No

21

With SVI _____ (1) Yes _____ (2) No

22

If Yes:

a. Are these agreements satisfactory?

With DRS _____ (1) Yes _____ (2) No

23

With SVI _____ (1) Yes _____ (2) No

24

If No:

a. Can these agreements be improved?

Explain _____

25 - 26

12. Does DRS or SVI help in the planning or implementation of any of your program to help the handicapped?

DRS: _____ (1) Yes _____ (2) No

27

SVI: _____ (1) Yes _____ (2) No

28

If No:

a. Would this be of any assistance to you if this help would be available?

From DRS _____ (1) Yes _____ (2) No

29

From SVI _____ (1) Yes _____ (2) No

30

13. Has DRS or SVI successfully assisted in the training and educating the handicapped in your area?

DRS: _____ (1) Yes _____ (2) No

31

SVI: _____ (1) Yes _____ (2) No

32

- . Do you have any suggestions for the improvement of the DRS or SVI program in your area? Would you list these suggestions below, directing your suggestions specifically to DRS or SVI or both, whatever the case may be.

33

34

- . During the past fiscal year how many clients or patients did your agency or facility service?

_____ (1) 0 - 50
 _____ (2) 51 - 100
 _____ (3) 101 - 300
 _____ (4) 301 - 500
 _____ (5) 501 - 1000
 _____ (6) 1001 - 2000
 _____ (7) 2001 - 5000
 _____ (8) Over 5000

35

36

- . What is your estimate of the number of people presently receiving your services who are chronically disabled?

_____ (1) 0 - 50
 _____ (2) 51 - 100
 _____ (3) 101 - 300
 _____ (4) 301 - 500
 _____ (5) 501 - 1000
 _____ (6) 1001 - 2000
 _____ (7) 2001 - 5000
 _____ (8) Over 5000

37

- . Does your agency have adequate facilities (such as handrails, ramps, parking facilities, doorways, restrooms, etc.) to facilitate the serving of handicapped patients?

_____ (1) Yes _____ (2) No

- . Do you assist handicapped persons in obtaining services that you do not offer?

_____ (1) Yes _____ (2) No

If yes:

38

39

1. Do you inform them of other organizations providing their services?

_____ (1) Yes _____ (2) No

40

2. Do you refer them to another agency or facility that provide these services?

_____ (1) Yes _____ (2) No

41

3. Do you provide or share your records to other approved service agencies?

_____ (1) Yes _____ (2) No

42

4. Do you participate in case conferences with other agencies?

_____ (1) Yes _____ (2) No

43

5. If there is a service charge, do you pay for the services to your client that you request from other agencies or facilities?

_____ (1) Yes _____ (2) No

44

6. Do you follow-up to make certain that your client receives the services?

_____ (1) Yes _____ (2) No

45

Is there a charge for your services?

_____ (1) Yes _____ (2) No

46

We are funded by the following means (check as many as apply):

_____ (1) Federal Government

47

_____ (2) State Government

_____ (3) County Government

_____ (4) City Government

48

_____ (5) United Community Services

_____ (6) Division of Rehabilitation Services

_____ (7) Services for the Visually Impaired

49

_____ (8) Foundations

_____ (9) Individual Contributions (Financial)

_____ (10) Contributions (Goods and Services)

50

_____ (11) Contributions through fund drives

_____ (12) Earned income through sales

_____ (13) Earned income through private clientele

_____ (14) Other _____

(Specify)

51

SPECIAL FACILITIES INFORMATION

The responses to the succeeding questions will be extremely helpful in assessing the types of services available to assist handicapped persons achieve maximum independence, now, and in the near future.

Listed below are departments usually found in Inpatient and Outpatient Medical Treatment Centers, Full Rehabilitation Centers and, to some extent, in specialized Rehabilitation facilities.

Preceding the name of each department or area are the letters NA (Not Applicable) and the numbers 1, 2, and 3.

Circle NA, to indicate that there is no department similar to the one described in your facility and you are not considering such a department in your future plans.

Circle 1, to denote that such a department is already functioning within your facility in a specially planned area designed for it. In the space following the item estimate the number of square feet allotted to it.

Circle 2, to denote that such a department is already functioning within your facility but not share or use space assigned to some other area. I.E., children's O.T. may be provided but the adult facility is utilized; in this case since there is no added square footage the number of the area where the service is administered is written in the space provided for square feet. Thus, if the Table Activities of Occupational Therapy was used as the site of Children's O.T., 43b would be entered in the space for "Area in Square Feet".

Circle 3, to indicate that such a department is in the planning state and/or is under construction, in "Area in Square Feet" give the number of square feet allocated to this area under construction.

For example: The Occupational Therapy Department (400 sq. ft.) has separate rooms for work bench activities (3000 sq. ft.). There is no Psychiatric O.T. department. The Children's O.T. is administered in the activities section of O.T. The information is presented as follows:

Occupational Therapy				Area in Square Feet	
NA	①	2	3	Workbench Activities	400 65
NA	①	2	3	Table Activities	3000 70
NA	1	2	3	Psychiatric Section	15
NA	1	②	3	Children's Section	43b 20

Begin with Item 41 below. Do not omit any item. Circle NA if not applicable or the correct number and follow the instructions for the number.

Medical Services					Area in Square Feet
NA	1	2	3	Physical and Medical Evaluation	15
NA	1	2	3	Medical Consultation on Premises	20
NA	1	2	3	Medical Consultation on Call	25
NA	1	2	3	Medical Supervision on Premises	30
NA	1	2	3	Psychiatric Screening	35
NA	1	2	3	Psychiatric Treatment	40
Physical Therapy					
NA	1	2	3	Rehabilitation Gymn	45
NA	1	2	3	Hydrotherapy (Whirl Pool)	50
NA	1	2	3	Hydrotherapy (Tanks, Pool)	55
NA	1	2	3	Thermotherapy and Massage	60
Occupational Therapy					
NA	1	2	3	Workbench Activities	65
NA	1	2	3	Table Activities	70
NA	1	2	3	Psychiatric Section	15
NA	1	2	3	Children's Section	20
Activities of Daily Living					
NA	1	2	3	Kitchen Activities	25
NA	1	2	3	Other Household Activities	30
NA	1	2	3	Personal Care (Dressing, Bathing, Toilet, ect.)	35
Artificial Appliance Dept.					
NA	1	2	3	Measuring and Fitting	40
NA	1	2	3	Manufacture of Limbs	45
NA	1	2	3	Manufacture of Braces	50
NA	1	2	3	Other	55
(Specify)					
Speech and hearing					
NA	1	2	3	Individual Therapy Room-Adults	60
NA	1	2	3	Individual Therapy Room-Children	65
NA	1	2	3	Group Therapy Room	70
NA	1	2	3	Anechoic Control and Testing Room	15
NA	1	2	3	Audiometric Scteening Room	20
Prevocational Unit					
NA	1	2	3	Workbench Activities	25
NA	1	2	3	Table Activities	30
Recreational Therapy Medically Supervised or Prescribed					
NA	1	2	3	Gymnasium	35
NA	1	2	3	Outdoor Activities	40

49. Nursing

a	NA	1	2	3	Supervision of Patient Care	4
b	NA	1	2	3	Supervision of Clients Medical Care	5
c	NA	1	2	3	Inservice Teaching and Counseling	5
d	NA	1	2	3	Other _____	6
				(Specify)		

50. Psychological Services

a	NA	1	2	3	Psychological Evaluation (Projectives, ect.)	6
b	NA	1	2	3	Personal Adjustment Counseling	7
c	NA	1	2	3	Group Therapy	1
d	NA	1	2	3	Other _____	2
				(Specify)		

51. Social Service

a	NA	1	2	3	Social Evaluation	2
b	NA	1	2	3	Social Casework	3
c	NA	1	2	3	Psychiatric Social Service	3
d	NA	1	2	3	Social Group Work	4

52. Vocational Services

a	NA	1	2	3	Vocational Evaluation	4
b	NA	1	2	3	Vocational Counseling	5
c	NA	1	2	3	Vocational Testing	5
d	NA	1	2	3	Special Education	6
e	NA	1	2	3	Vocational Training	6
f	NA	1	2	3	Vocational Placement	7
g	NA	1	2	3	Work Evaluation	1
h	NA	1	2	3	Work Adjustment	2
i	NA	1	2	3	Placement	2

53. Recreation - Non Medical

a	NA	1	2	3	Camping Area	3
b	NA	1	2	3	Boy Scout Troop (Handicapped)	3
c	NA	1	2	3	Girl Scout Troop (Handicapped)	4
d	NA	1	2	3	Supervised Social Functions	4
e	NA	1	2	3	Other _____	5
				(Specify)		

IMPORTANT INSTRUCTIONS

PLEASE READ BEFORE PROCEEDING

The questions in this booklet were designed to help you evaluate your position as well as your relationships to other health services with whom you may work. The information that we gather from this Questionnaire can be very meaningful to Statewide Planning inasmuch as it constitutes an inventory of professional personnel working within the State together with the focus of their activities. Here is also the opportunity for the professional person to compare and evaluate his present procedures with what he may feel may be a more effective scheduling of his time.

To effect a comparison of standards you will note that in many cases a question will deal with the situation as it is. A subsequent question will request you to review the same list again and record on the opposite side what you feel could be a more efficient method or arrangement of your time for more effective performance. In practically every circumstance you will find that all the effort required on your part is to check or circle the desired solution. Occasionally a word or short phrase may be necessary.

We are asking you to evaluate and respond to these questions as carefully as you can. Let the responses be what you think and feel and not what you feel your co-workers or department heads would think. This is your opportunity to express how you feel about many areas of your work and to find out how they agree with those of your co-workers. Your responses will remain completely anonymous; the statements are worded in such a way that an outside concern will be able to take your responses and provide this office with a meaningful report. The questionnaire results will not be considered on an individual basis but collectively according to group.

It will be particularly appreciated if you will fill out this Questionnaire immediately and send it by return mail. A self-addressed stamped envelope is enclosed for your convenience.

This may be the only time that you will be able to express your opinions of working conditions on a collective basis in a fashion that can be effectively utilized, not only in your field, but in the area of Rehabilitation. Do not deprive yourself or your co-workers of this opportunity to avail yourselves of this valuable information.

If you wish to make additional comments, please use the space provided on the last page of the booklet. This Questionnaire was prepared by the staff of Statewide Planning for Rehabilitation Services office. We thank you for filling it out.

OPERATING LEVEL AND EVALUATION QUESTIONNAIRE *

Sex _____ (13) _____

Age _____ (14-15) _____

How many counties does your agency or office serve? _____ (16-17)

How many counties do you personally serve? _____ (18-19)

Name the county in which your office is located. _____ (20-21)

Check before the statement the highest level of formal education completed:

- | | | | | |
|------|---|------------------------------------|---|------|
| (22) | 0 | Less than High School Graduate | 0 | (23) |
| | 1 | High School Graduate | 1 | |
| | 2 | Some College Training | 2 | |
| | 3 | Two Year College Certificate | 3 | |
| | 4 | Less than BA | 4 | |
| | 5 | Bachelors Degree | 5 | |
| | 6 | Bachelor of Divinity or Equivalent | 6 | |
| | 7 | Some Graduate Work | 7 | |
| | 8 | Master's Degree | 8 | |
| | 9 | M.D., Ph.D. or Equivalent | 9 | |

On above level of Education Scale, check behind the statement the level of formal education recommended or required for your position.

Check the basic responsibility in your job in the space left of the items below

- | | | | | |
|---------|-----|----------------------|-----|-----------------|
| (24-25) | 01 | Administration | 01 | (26-27) |
| | 02 | Counseling | 02 | |
| | 03 | Coordination | 03 | |
| | 04 | Case Worker | 04 | |
| | 05 | Diagnosis | 05 | |
| | 06 | Pastoral Duties | 06 | |
| | 07 | Patient Services | 07 | |
| | 08 | Record Keeping | 08 | |
| | 09 | Supervision | 09 | |
| | 10 | Vocational Placement | 10 | |
| | 11+ | Other _____ | 11+ | _____ (Specify) |

Check the secondary responsibility in your work in the column to the right of the above listed items.

Check the appropriate classification below:

- (28) 1 ☐ Salaried
 2 ☐ Paid on hourly basis
 3 ☐ Part-time
 4 ☐ Consultant
 5 ☐ Volunteer/Community Service Worker

If 1, 2, 3 or 4 above is checked answer "a" and "b" below:

a. Compared with other persons employed in comparable positions within the State do you feel that the salary for your position is: (Mark response on the left of the table below)

- | | | |
|---|----------------------------|------|
| (29) 1 <input type="checkbox"/> Adequate | <input type="checkbox"/> 1 | (30) |
| 2 <input type="checkbox"/> Too Low | <input type="checkbox"/> 2 | |
| 3 <input type="checkbox"/> Above Average | <input type="checkbox"/> 3 | |
| 4 <input type="checkbox"/> Low enough to cause dissatisfaction and eventual loss or transfer of personnel | <input type="checkbox"/> 4 | |
| 5 <input type="checkbox"/> High enough to attract excellent personnel from other departments or geographical areas. | <input type="checkbox"/> 5 | |

b. Compared with other persons employed in similar positions outside of the State, do you feel that the salaries paid are: (Mark response on right of the table above).

How long have you been employed?

- (31) 1 ☐ Less than 6 months
 2 ☐ 6 months to 1 year
 3 ☐ 1 year to 2 years
 4 ☐ 2 years to 4 years
 5 ☐ 4 years to 6 years
 6 ☐ 6 years to 10 years
 7 ☐ 10 years to 12 years
 8 ☐ 12 years to 15 years
 9 ☐ 15 years and above

Your training and education - Check major area:

- (32-33) 01 ☐ Audiology
 02 ☐ Business Administration
 03 ☐ Business College
 04 ☐ Counseling and Guidance
 05 ☐ Education
 06 ☐ Medicine
 07 ☐ Nursing R.N.
 08 ☐ Nursing P.N.
 09 ☐ Occupational Therapy

10. ☐ Orthotics
- 11 ☐ Physical Therapy
- 12 ☐ Prosthetics
- 13 ☐ Psychology
- 14 ☐ Rehabilitation
- 15 ☐ Religious Ministry
- 16 ☐ Social Work
- 17 ☐ Sociology
- 18 ☐ Speech Therapy
- 19 ☐ Special Education
- 20 ☐ Trade School _____
- 21 ☐ Other _____ (Specify)

(Specify)

Are Clients referred to your agency?

(34) 1 ☐ Yes

2 ☐ No

If Yes, what are the four most frequent sources of referral - Circle number 1 for the most frequent, 2 for the second most frequent, 3 for the third most frequent, and 4 for the fourth most frequent.

- (35) 1 2 3 4 Vocational Rehabilitation Services
- (36) 1 2 3 4 Services for the Visually Impaired
- (37) 1 2 3 4 Public Educational Institutions
- (38) 1 2 3 4 Private Educational Institutions
- (39) 1 2 3 4 Public Hospitals or Sanitoriums
- (40) 1 2 3 4 Private Hospitals or Sanitoriums
- (41) 1 2 3 4 Public Health Agencies
- (42) 1 2 3 4 Private Health Agencies
- (43) 1 2 3 4 Welfare Agencies
- (44) 1 2 3 4 Individuals
- (45) 1 2 3 4 Physicians
- (46) 1 2 3 4 Self-Referred
- (47) 1 2 3 4 U.S. Employment Services
- (48) 1 2 3 4 Churches

Check area or individual most closely associated with, or employed by:

- (49-50) 01 ☐ Elementary or Secondary School
- 02 ☐ State Vocational School
- 03 ☐ Private Vocational Schools
- 04 ☐ College or University
- 05 ☐ School for Physically Handicapped
- 06 ☐ School for Mentally Handicapped

- 07_____Mental Hospital
- 08_____General Hospital
- 09_____Crippled Children's Society
- 10_____Arthritis Foundation
- 11_____Division of Rehabilitation for the
Visually Impaired
- 12_____Other Blind Service Agency
- 13_____Cancer Society
- 14_____Cerebral Palsy Foundation
- 15_____Epilepsy Foundation
- 16_____Deaf and Hard of Hearing
- 17_____Heart Foundation
- 18_____Mental Retardation Association
- 19_____Mental Health Organization
- 20_____Multiple Sclerosis Organization
- 21_____Tuberculosis
- 22_____Social Security Administration
- 23_____State Workmen's Compensation
- 24_____State Welfare Agency
- 25_____Private Welfare Agency (Salvation Army,
Goodwill Industries, etc.)
- 26_____Labor Union Welfare
- 27_____State Employment Service
- 28_____Insurance Company
- 29_____Penal Institution
- 30_____Correction
- 31_____Parole Officers
- 32_____Juvenile Courts
- 33_____Division of Vocational Rehabilitation
- 34_____Church
- 35_____Community Council
- 36_____Group concerned with employment of minorities
- 37_____Group serving a particular minority
- 38_____Other_____

(Specify)

5. What percentage of your time is spent on the following duties (considering 1 as 10%, 2 as 20%, etc., circle the correct number on the left of the response).

61)	1 2 3 4 5 6 7 8 9	Interview	1 2 3 4 5 6 7 8 9	(73)
62)	1 2 3 4 5 6 7 8 9	Clerical Duties	1 2 3 4 5 6 7 8 9	(74)
63)	1 2 3 4 5 6 7 8 9	Home Visits	1 2 3 4 5 6 7 8 9	(75)
64)	1 2 3 4 5 6 7 8 9	Placements	1 2 3 4 5 6 7 8 9	(76)
65)	1 2 3 4 5 6 7 8 9	Staffings	1 2 3 4 5 6 7 8 9	(77)
66)	1 2 3 4 5 6 7 8 9	Inter-Agency Conferences	1 2 3 4 5 6 7 8 9	(78)
67)	1 2 3 4 5 6 7 8 9	Volunteer Community Service Work	1 2 3 4 5 6 7 8 9	(13)
68)	1 2 3 4 5 6 7 8 9	Supervision	1 2 3 4 5 6 7 8 9	(14)
69)	1 2 3 4 5 6 7 8 9	Individual Personnel Conferences	1 2 3 4 5 6 7 8 9	(15)
70)	1 2 3 4 5 6 7 8 9	Telephone Contacts	1 2 3 4 5 6 7 8 9	(16)
71)	1 2 3 4 5 6 7 8 9	Psychodiagnostics	1 2 3 4 5 6 7 8 9	(17)
72)	1 2 3 4 5 6 7 8 9	Direct Services (i.e., P.T., Nursing, OT., etc.)	1 2 3 4 5 6 7 8 9	(18)
73)	1 2 3 4 5 6 7 8 9	Teaching and Training	1 2 3 4 5 6 7 8 9	(19)
74)	1 2 3 4 5 6 7 8 9	Work Evaluation	1 2 3 4 5 6 7 8 9	(20)
75)	1 2 3 4 5 6 7 8 9	Counseling	1 2 3 4 5 6 7 8 9	(21)
76)	1 2 3 4 5 6 7 8 9	Public Relations	1 2 3 4 5 6 7 8 9	(22)
77)	1 2 3 4 5 6 7 8 9	Creative Work-Origination-Idea Development	1 2 3 4 5 6 7 8 9	(23)
78)	1 2 3 4 5 6 7 8 9	Recording - Writing Up	1 2 3 4 5 6 7 8 9	(24)
79)	1 2 3 4 5 6 7 8 9	Organization	1 2 3 4 5 6 7 8 9	(25)
80)	1 2 3 4 5 6 7 8 9	State and National Conferences	1 2 3 4 5 6 7 8 9	(26)
81)	1 2 3 4 5 6 7 8 9	Coordination	1 2 3 4 5 6 7 8 9	(27)
82)	1 2 3 4 5 6 7 8 9	Furtherance of Professional Skills, e.g., Reading, Attending Classes, etc.	1 2 3 4 5 6 7 8 9	(28)

6. In order to utilize your time more effectively, what percentage of time do you feel should be spent on the duties given in the table above? (Considering 1 as 10%, 2 as 20%, etc., circle the correct number on the right side of the above table.)

7. If you have the responsibility for a case load, check on the left side of the table below the interval that contains the average size of your case load.

(29)	1 _____	1 - 24	_____ 1	(30)
	2 _____	25 - 49	_____ 2	
	3 _____	50 - 74	_____ 3	
	4 _____	75 - 99	_____ 4	
	5 _____	100 - 124	_____ 5	
	6 _____	125 - 149	_____ 6	
	7 _____	150 - 199	_____ 7	
	8 _____	200 - 249	_____ 8	
			_____ 9	

6.

Check on the right side of the above table the interval that contains what you consider the ideal case load number to carry for the type clients you service. Make a check mark in the left column next to the interval that contains the number of clients that you see in a weeks time.

(31)	1 _____	Less than 5	_____ 1	(32)
	2 _____	5 - 9	_____ 2	
	3 _____	10 - 14	_____ 3	
	4 _____	15 - 19	_____ 4	
	5 _____	20 - 24	_____ 5	
	6 _____	25 - 29	_____ 6	
	7 _____	30 - 34	_____ 7	
	8 _____	35 - 39	_____ 8	
	9 _____	40 or more	_____ 9	

Check in the right side of the above table the interval that contains the number of clients that you feel can be serviced most adequately in a weeks time. Check in the left column below, the interval which contains the number which most closely approximates the number of closures, placements or case disposition you average in a months time.

(33)	1 _____	Less than 5	_____ 1	(34)
	2 _____	5 - 9	_____ 2	
	3 _____	10 - 14	_____ 3	
	4 _____	15 - 19	_____ 4	
	5 _____	20 - 24	_____ 5	
	6 _____	25 - 29	_____ 6	
	7 _____	30 - 34	_____ 7	
	8 _____	35 - 39	_____ 8	
	9 _____	40 or more	_____ 9	

Check in the right column of the above table, the interval that contains the number of closures, placements or case dispositions that you feel you should ideally obtain from your case load per month.

How many different clients have you served in the last 12 months?

(35)	1 _____	1 - 24	_____ 1	(36)
	2 _____	25 - 49	_____ 2	
	3 _____	50 - 74	_____ 3	
	4 _____	75 - 99	_____ 4	
	5 _____	100 - 149	_____ 5	
	6 _____	150 - 199	_____ 6	
	7 _____	200 - 249	_____ 7	
	8 _____	250 - 299	_____ 8	
	9 _____	300 or more	_____ 9	

24. In the column on the right side of the table above, check opposite the inter that contains the number of clients that you feel you could more efficiently serve during a 12 month period.

25. What percentage of the persons referred to you are you unable to serve?

(37)	1 _____	1 - 5%	_____ 1	(38-39)
	2 _____	6 - 10%	_____ 2	
	3 _____	11 - 15%	_____ 3	
	4 _____	16 - 20%	_____ 4	
	5 _____	21 - 25%	_____ 5	
	6 _____	26 - 30%	_____ 6	
	7 _____	31 - 35%	_____ 7	
	8 _____	36 - 40%	_____ 8	
	9 _____	Over 40%	_____ 9	

26. In a 12 month period approximately what actual number of cases would this percentage figure represent? (Write this figure in the space to the right of the above table opposite the percentage figure checked.)

27. Was this inability to provide service due to:

- 1 _____ Lack of Space (40)
- 2 _____ Lack of Qualified Personnel
- 3 _____ Lack of Proper Equipment
- 4 _____ Lack of Adequate Financing (43)
- 5 _____ Inability to Cover the Entire Territory
- 6 _____ Inability of the client to meet qualifications
Standards
- 7 _____ Inability to Obtain all Needed Services in
Local Area _____ (44, 45)
(Specify)

28. Approximately what percentage of the group that you serve are: (Considering as 10%, 2 as 20%, etc., circle the correct number on the left of the respons

- (46) 1 2 3 4 5 6 7 8 9 Indigent
- (47) 1 2 3 4 5 6 7 8 9 Culturally Deprived
- (48) 1 2 3 4 5 6 7 8 9 Mentally Retarded
- (49) 1 2 3 4 5 6 7 8 9 Neuro-Psychiatric Problems
- (50) 1 2 3 4 5 6 7 8 9 Physically Handicapped
- (51) 1 2 3 4 5 6 7 8 9 From Rural Area
- (52) 1 2 3 4 5 6 7 8 9 From Urban Area
- (53) 1 2 3 4 5 6 7 8 9 Under 16 years of age
- (54) 1 2 3 4 5 6 7 8 9 Ages 16 - 50
- (55) 1 2 3 4 5 6 7 8 9 Over 50 Years Old

8.

Indicate the scope of services rendered or provided by your agency by circling the appropriate number to the left of the services itemized below. Circle NA (Not Applicable) for any item not pertinent to your agencies operation.

Circle 1, the services you are able to provide the client from within your agency. Circle 2, the services you are permitted to purchase for your client from outside sources. Circle 3, those services which you cannot provide nor purchase for your clients from outside resources but may be a valuable adjunct to your services.

(56)	NA	1	2	3	Adoption Services	1	2	3	(13)
(57)	NA	1	2	3	After Care Services	1	2	3	(14)
(58)	NA	1	2	3	Aid to the Blind (Financial)	1	2	3	(15)
(59)	NA	1	2	3	Aid to the Disabled (Financial)	1	2	3	(16)
(60)	NA	1	2	3	Aid to Families with Dependent Children (Financial)	1	2	3	(17)
(61)	NA	1	2	3	Alcoholism, Treatment of	1	2	3	(18)
(62)	NA	1	2	3	College Training	1	2	3	(19)
(63)	NA	1	2	3	Convalescent and Nursing Home Care	1	2	3	(20)
(64)	NA	1	2	3	Counseling, Individual	1	2	3	(21)
(65)	NA	1	2	3	Counseling, Marriage	1	2	3	(22)
(66)	NA	1	2	3	Counseling, Vocational	1	2	3	(23)
(67)	NA	1	2	3	Court Social Service	1	2	3	(24)
(68)	NA	1	2	3	Crippled Childrens Service	1	2	3	(25)
(69)	NA	1	2	3	Drug Addiction, Treatment of	1	2	3	(26)
(70)	NA	1	2	3	Education, Formal	1	2	3	(27)
(71)	NA	1	2	3	Employment, Counseling	1	2	3	(28)
(72)	NA	1	2	3	Employment, Placement	1	2	3	(29)
(73)	NA	1	2	3	Eye Glasses	1	2	3	(30)
(74)	NA	1	2	3	Foster Home Placement	1	2	3	(31)
(75)	NA	1	2	3	General Assistance (Financial)	1	2	3	(32)
(76)	NA	1	2	3	Health Information	1	2	3	(33)
(77)	NA	1	2	3	Health Insurance for Aged (Medicare)	1	2	3	(34)
(78)	NA	1	2	3	Hearing Aids	1	2	3	(35)
(13)	NA	1	2	3	Housing for the Aged	1	2	3	(36)
(14)	NA	1	2	3	Housing for the Physically Disabled	1	2	3	(37)
(15)	NA	1	2	3	Housing for the Retarded	1	2	3	(38)
(16)	NA	1	2	3	Job Engineering	1	2	3	(39)
(17)	NA	1	2	3	Job Finding	1	2	3	(40)
(18)	NA	1	2	3	Maintenance (Financial Aid During Training)	1	2	3	(41)
(19)	NA	1	2	3	Maternal and Child Health Services	1	2	3	(42)

Mental Health Services (In-Patient)

(20)	NA	1	2	3	Hospitalization (Private Hospital)	1	2	3	(43)
(21)	NA	1	2	3	Hospitalization (Public Facility)	1	2	3	(44)
(22)	NA	1	2	3	Occupational Therapy	1	2	3	(45)
(23)	NA	1	2	3	Psychiatric Examination	1	2	3	(46)
(24)	NA	1	2	3	Psychiatric Treatment	1	2	3	(47)
(25)	NA	1	2	3	Psychological Evaluation (Clinical)	1	2	3	(48)
(26)	NA	1	2	3	Psychotherapy	1	2	3	(49)
(27)	NA	1	2	3	Social Service	1	2	3	(50)
(28)	NA	1	2	3	Therapeutic Recreation	1	2	3	(51)

Mental Health Services Out-Patient)

(29)	NA	1	2	3	After Care	1	2	3	(52)
(30)	NA	1	2	3	Clinic Services	1	2	3	(53)
(31)	NA	1	2	3	Medication	1	2	3	(54)
(32)	NA	1	2	3	Psychiatric Examination	1	2	3	(55)
(33)	NA	1	2	3	Psychiatric Treatments	1	2	3	(56)
(34)	NA	1	2	3	Psychological Evaluation (Clinical)	1	2	3	(57)
(35)	NA	1	2	3	Psychotherapy	1	2	3	(58)
(36)	NA	1	2	3	Social Service	1	2	3	(59)
(37)	NA	1	2	3	Old-Age Survivors and Disability	1	2	3	(60)

Insurance

Physical Health Services (In-Patient)

(38)	NA	1	2	3	Activities of Daily Living	1	2	3	(61)
(39)	NA	1	2	3	Audiology Examination	1	2	3	(62)
(40)	NA	1	2	3	Dental Procedure	1	2	3	(63)
(41)	NA	1	2	3	Hospitalization (Private Hospital)	1	2	3	(64)
(42)	NA	1	2	3	Hospitalization (Public Facility)	1	2	3	(65)
(43)	NA	1	2	3	Medical Examination	1	2	3	(66)
(44)	NA	1	2	3	Medication - Control of Acute	1	2	3	(67)

Conditions

(45)	NA	1	2	3	Medication - Control of Chronic	1	2	3	(68)
------	----	---	---	---	---------------------------------	---	---	---	------

Disease

(46)	NA	1	2	3	Medication - Control of Chronic	1	2	3	(69)
------	----	---	---	---	---------------------------------	---	---	---	------

Pain

(47)	NA	1	2	3	Mobility Instruction	1	2	3	(70)
(48)	NA	1	2	3	Nursing Care (Private)	1	2	3	(71)
(49)	NA	1	2	3	Occupational Therapy	1	2	3	(72)
(50)	NA	1	2	3	Orthotics and Prosthetics	1	2	3	(73)

(51)	NA	1	2	3	Physical Therapy	1	2	3	(74)
(52)	NA	1	2	3	Psychological Evaluation	1	2	3	(75)
(53)	NA	1	2	3	Social Work - Case Work	1	2	3	(76)
(54)	NA	1	2	3	Social Work - Group	1	2	3	(77)
(55)	NA	1	2	3	Speech Therapy	1	2	3	(78)
(56)	NA	1	2	3	Surgical Procedures - Major	1	2	3	(13)
(57)	NA	1	2	3	Surgical Procedures - Minor	1	2	3	(14)
<u>Physical Health Services</u> - (Out-Patient)									
(58)	NA	1	2	3	Audiology Examination	1	2	3	(15)
(59)	NA	1	2	3	Dental Procedures	1	2	3	(16)
(60)	NA	1	2	3	Medical Examination	1	2	3	(17)
(61)	NA	1	2	3	Medication -Control of Acute	1	2	3	(18)
Condition									
(62)	NA	1	2	3	Medication -Control of Chronic	1	2	3	(19)
Disease									
(63)	NA	1	2	3	Medication - Control of Chronic	1	2	3	(20)
Pain									
(64)	NA	1	2	3	Orthotics and Prosthetics	1	2	3	(21)
(65)	NA	1	2	3	Physical Therapy	1	2	3	(22)
(66)	NA	1	2	3	Psychological Evaluation (Vocational)	1	2	3	(23)
(67)	NA	1	2	3	Social Work - Case Work	1	2	3	(24)
(68)	NA	1	2	3	Social Work - Group	1	2	3	(25)
(69)	NA	1	2	3	Speech Therapy	1	2	3	(26)
(70)	NA	1	2	3	Tools and Equipment	1	2	3	(27)
(71)	NA	1	2	3	Transportation	1	2	3	(28)
(72)	NA	1	2	3	Trade School Training	1	2	3	(29)
(73)	NA	1	2	3	Visiting Nurse	1	2	3	(30)
(74)	NA	1	2	3	Vocational Guidance	1	2	3	(31)
(75)	NA	1	2	3	Vocational Testing	1	2	3	(32)
(76)	NA	1	2	3	Vocational Training	1	2	3	(33)
(77)	NA	1	2	3	Work Adjustment	1	2	3	(34)
(78)	NA	1	2	3	Work Evaluation	1	2	3	(35)

For services other than the two Rehabilitation Services, indicate the scope of services rendered by the Division of Rehabilitation Services and the Services for the Visually Impaired by circling the numbers to the right of the above list in accordance with the following instructions: Circle 1, to indicate the services provided by the Division of Rehabilitation Services to their clients. Circle 2, to indicate services provided by the Services for the Visually Impaired to their clients. Circle 3, to indicate the additional services that you feel should be extended to the clients of both rehabilitation services.

1. On the left side of the statement below check how much individual responsibility you have for making decisions about the cases assigned to you or in your work

- | | | | | | |
|------|---|---|-------|---|------|
| (36) | 1 | Complete Responsibility | _____ | 1 | (37) |
| | 2 | Complete Responsibility, some consultation with the supervisor. | _____ | 2 | |
| | 3 | Some responsibility, some supervision. | _____ | 3 | |
| | 4 | Little responsibility, great amount of supervision. | _____ | 4 | |
| | 5 | Completely supervised. | _____ | 5 | |

2. On the right side of the above statements check how much individual responsibility you feel you should have for making decisions about the cases assigned to you in your work.

3. Place a check mark on the left side opposite the statement below which reflects the amount of independent action you have in dealing with your case load or in your work.

- | | | | | | |
|------|---|---|-------|---|------|
| (38) | 1 | Complete | _____ | 1 | (39) |
| | 2 | Almost complete, some consultation | _____ | 2 | |
| | 3 | Moderate, have to consult on most cases | _____ | 3 | |
| | 4 | None, have to consult on all cases or courses of action | _____ | 4 | |

4. Place a check mark on the right side of the above statement that reflects most clearly how you feel about the amount of independence of action you should have in your work.

5. What percent of your clients are referred to:

- | | | |
|---|---------|----------|
| The Division of Rehabilitation Services | _____ % | (40, 41) |
| The Services for the Visually Impaired | _____ % | (42, 43) |

6. When your clients are referred to another agency for services is their case file closed?

- | | | | | |
|---|-----|---|----|------|
| 1 | Yes | 2 | No | (44) |
|---|-----|---|----|------|

7. When your clients are referred to another agency, do you request a report as to the disposition of the client's case?

- | | | | | |
|---|-----|---|----|------|
| 1 | Yes | 2 | No | (45) |
|---|-----|---|----|------|

Do you "follow up" on clients referred to other agencies? Yes _____ No _____ (46)

Do you find, in most cases, that the agencies usually comply with your request for reports. 1 _____ Yes 2 _____ No. (47)

If No: Would you list below the names of the agency or agencies that do not comply with your request? _____ (48)

8. Do you regularly "follow up" on your own closed cases? 1 _____ Yes 2 _____ No
If Yes:

a. Is your follow up done within:

1 _____ 1 month

2 _____ 3 months

3 _____ 6 months

4 _____ 1 year

b. Approximately, what percentage of your closed cases: (considering 1 as 10%, 2 as 20%, etc., circle the correct number on the left of the response)

(51) 1 2 3 4 5 6 7 8 9 Do not return to work?

(52) 1 2 3 4 5 6 7 8 9 Obtain employment?

(53) 1 2 3 4 5 6 7 8 9 Return to their former job?

(54) 1 2 3 4 5 6 7 8 9 Return to a different employer?

(55) 1 2 3 4 5 6 7 8 9 Change their field of work?

(56) 1 2 3 4 5 6 7 8 9 Are referred to another agency for counseling,
training and employment?

9. Do you have any of the following centers, agencies or professional personnel readily available to you? (Check those centers or agencies immediately available to the left of the list below):

1 _____ Rehabilitation Center (57)

2 _____ Evaluation Workshop (58)

3 _____ Sheltered Workshop (59)

4 _____ Division of Rehabilitation Services Office (60)

5 _____ Services for the Visually Impaired Office (61)

6 _____ U. S. Employment Services (62)

7 _____ Mental Health Centers (63)

8 _____ Training Facilities for the Mentally Retarded (64)

9 _____ Psychologist (65)

10 _____ Speech Therapist (66)

11 _____ Physical Therapist (67)

Use the following scale to answer the subsequent question.

1. In the city

2. Less than 25 miles

3. 26 to 50 miles

4. 51 to 75 miles

5. 76 to 100 miles

6. 101 to 125 miles

7. 125 to 150 miles

8. Over 150 miles

9. Out of the state

a. How close is the nearest center or agency? (Circle the number to the left of the list below that most closely corresponds to the distance as listed in the above scale):

- (68) 1 2 3 4 5 6 7 8 9 Rehabilitation Center
- (69) 1 2 3 4 5 6 7 8 9 Evaluation Workshop
- (70) 1 2 3 4 5 6 7 8 9 Sheltered Workshop
- (71) 1 2 3 4 5 6 7 8 9 Division of Rehabilitation Services
- (72) 1 2 3 4 5 6 7 8 9 Services for the Visually Impaired
- (73) 1 2 3 4 5 6 7 8 9 U. S. Employment Services
- (74) 1 2 3 4 5 6 7 8 9 Mental Health Center
- (75) 1 2 3 4 5 6 7 8 9 Training Center for the Mentally Retarded
- (76) 1 2 3 4 5 6 7 8 9 Psychologist
- (77) 1 2 3 4 5 6 7 8 9 Speech Therapist
- (78) 1 2 3 4 5 6 7 8 9 Physical Therapist

(If any center, facility, agency or professional person is too far distant for practical utilization of services in all but extreme cases, considering 1 as 10%, 2 as 20%, etc., circle the correct number to the left of the list below according to the following question):

b. What percentage of your clients would benefit from the services of each of the facilities listed below if they were available?

- (13) 1 2 3 4 5 6 7 8 9 Rehabilitation Center 1 2 3 4 5 6 7 8 9 (24)
- (14) 1 2 3 4 5 6 7 8 9 Evaluation Workshop 1 2 3 4 5 6 7 8 9 (25)
- (15) 1 2 3 4 5 6 7 8 9 Sheltered Workshop 1 2 3 4 5 6 7 8 9 (26)
- (16) 1 2 3 4 5 6 7 8 9 Division of Rehabilitation Services 1 2 3 4 5 6 7 8 9 (27)
- (17) 1 2 3 4 5 6 7 8 9 Services for the Visually Impaired 1 2 3 4 5 6 7 8 9 (28)
- (18) 1 2 3 4 5 6 7 8 9 U.S. Employment Services 1 2 3 4 5 6 7 8 9 (29)
- (19) 1 2 3 4 5 6 7 8 9 Mental Health Center 1 2 3 4 5 6 7 8 9 (30)
- (20) 1 2 3 4 5 6 7 8 9 Training Facilities for the Mentally Retarded 1 2 3 4 5 6 7 8 9 (31)
- (21) 1 2 3 4 5 6 7 8 9 Psychologist 1 2 3 4 5 6 7 8 9 (32)
- (22) 1 2 3 4 5 6 7 8 9 Speech Therapist 1 2 3 4 5 6 7 8 9 (33)
- (23) 1 2 3 4 5 6 7 8 9 Physical Therapist 1 2 3 4 5 6 7 8 9 (34)

c. What percentage of extreme cases would you have to refer to the above listed services in spite of the inconvenience caused by the distance? (Circle the appropriate number to the right of the above list of services according to the percentage scale given above.)

Use the following rating scale to answer the following question and any other subsequent rating question:

1. Very good, all services excellent, staff excellent.
2. Good, cooperative, some time and/or space problems.
3. Fair, services inconsistent.
4. Unsatisfactory, uncooperative, lacking in time and facilities.
5. Very unsatisfactory, services poor, reports inadequate, staff inadequate.

d. How would you rate the services you have received from these agencies or facilities? (Circle the correct number preceding each facility or agency according to the rating scale given above:)

- (35) 1 2 3 4 5 Rehabilitation Center
- (36) 1 2 3 4 5 Evaluation Workshop
- (37) 1 2 3 4 5 Sheltered Workshop
- (38) 1 2 3 4 5 Division of Rehabilitation Services
- (39) 1 2 3 4 5 Services for the Visually Impaired
- (40) 1 2 3 4 5 U. S. Employment Service
- (41) 1 2 3 4 5 Mental Health Center
- (42) 1 2 3 4 5 Training Facilities for the Mentally Retarded
- (43) 1 2 3 4 5 Psychologist
- (44) 1 2 3 4 5 Speech Therapist
- (45) 1 2 3 4 5 Physical Therapist

If 3, 4 or 5 is checked for any agency, facility or professional person, answer the questions below:

e. Is there an alternate facility, agency or professional person elsewhere that can be utilized if necessary? 1 _____ Yes 2 _____ No (46)

If Yes:

f. How far distant is this service located? (Circle the correct number to the left of the facility or person listed below according to the distance scale listed previously within this question):

- (47) 1 2 3 4 5 6 7 8 9 Rehabilitation Center
- (48) 1 2 3 4 5 6 7 8 9 Evaluation Workshop
- (49) 1 2 3 4 5 6 7 8 9 Sheltered Workshop
- (50) 1 2 3 4 5 6 7 8 9 Division of Rehabilitation Services
- (51) 1 2 3 4 5 6 7 8 9 Services for the Visually Impaired
- (52) 1 2 3 4 5 6 7 8 9 U. S. Employment Service
- (53) 1 2 3 4 5 6 7 8 9 Mental Health Center
- (54) 1 2 3 4 5 6 7 8 9 Training Center for the Mentally Retarded
- (55) 1 2 3 4 5 6 7 8 9 Psychologist
- (56) 1 2 3 4 5 6 7 8 9 Speech Therapist
- (57) 1 2 3 4 5 6 7 8 9 Physical Therapist

g. Have you used any of these alternate services? 1 _____ Yes 2 _____ No
If Yes, would you rate the effectiveness of these services by circling
the correct number preceding the services utilizing the rating scale given
previously:

- (59) 1 2 3 4 5 Rehabilitation Center
- (60) 1 2 3 4 5 Evaluation Workshop
- (61) 1 2 3 4 5 Sheltered Workshop
- (62) 1 2 3 4 5 Division of Rehabilitation Services
- (63) 1 2 3 4 5 Services for the Visually Impaired
- (64) 1 2 3 4 5 U. S. Employment Services
- (65) 1 2 3 4 5 Mental Health Center
- (66) 1 2 3 4 5 Training Center for the Mentally Retarded
- (67) 1 2 3 4 5 Psychologist
- (68) 1 2 3 4 5 Speech Therapist
- (69) 1 2 3 4 5 Physical Therapist

h. Are you a member of the Rehabilitation Association of Nebraska?

1 _____ Yes

2 _____ No

If Yes: Are you a member of NRCA? 1 _____ Yes 2 _____ No

If No:

1. Has anyone ever asked you to join RAN? 1 _____ Yes 2 _____ No

2. Are you interested in become a member of RAN?

1 _____ Yes

2 _____ No

i. How much knowledge gained from your class room work were you able to apply
to your own work?

1 _____ Very little.

2 _____ Some, but not too much.

3 _____ Quite a bit but more was learned on the job.

4 _____ More than from any other source.

5 _____ Almost all of it.

j. How many hours a week are you allowed to take off per week to attend extension
courses, conferences, or other functions intended to further your professional
skills:

1 _____ None

2 _____ 1 - 3

3 _____ 4 - 6

4 _____ 7 - 9

5 _____ 10 - 12

6 _____ 13 - 15

7 _____ 16 - 19

8 _____ 20 hours or more

16.

How many hours per week of your own time are spent in taking extension courses, reading professional journals, attending conferences, or other functions intended to further your professional training? (20)

- 1 _____ None
- 2 _____ 1 - 3
- 3 _____ 4 - 6
- 4 _____ 7 - 9
- 5 _____ 10 - 12
- 6 _____ 13 - 15
- 7 _____ 16 - 19
- 8 _____ 20 hours or more

Does your agency have a pre-service orientation and training program that precedes the first duty assignment? 1 _____ Yes 2 _____ No (21)

How do you evaluate the introductory training you received on your job?

- 1 _____ No training at all, had to virtually teach myself the elementary aspects. (22)
- 2 _____ Very inadequate, brief rotation with various members of the office staff for orientation purposes. Immediate assignment to job.
- 3 _____ Fair - Given introductory literature, opportunity to get acquainted with the functions of the various staff members before definite assignment.
- 4 _____ Good - Same as 3 with opportunity to work for a short period of time with an experienced co-worker preceding first duty assignment.
- 5 _____ Very good - Same as above with an honest attempt to provide additional adequate procedural training before initial assignment.
- 6 _____ Excellent - All of the above together with thorough indoctrination in job techniques, progress conferences with peers and superiors preceding first duty assignments.

How much time is allotted to pre-service orientation and training?

- 1 _____ 1 day (23)
- 2 _____ 1 to 7 days
- 3 _____ 1 to 2 weeks
- 4 _____ 2 to 4 weeks
- 5 _____ 1 to 2 months
- 6 _____ 2 to 3 months
- 7 _____ 3 to 6 months
- 8 _____ 6 months and over

Is there an In-Service Training Program for your professional and administrative staff? 1 _____ Yes 2 _____ No (24)

48. Is there an opportunity to work with other individuals assigned to similar work in other areas than assigned to you? 1____Yes 2____No (25)
49. Are there in-service programs to familiarize the employee with procedures performed by others whose work will definitely affect this production?
1____Yes 2____No (26)
50. Is the in-service program primarily limited to the locality in which the employee is going to be working? 1____Yes 2____No (27)
51. Are there opportunities for in-service program in cooperation with other agencies? 1____Yes 2____No (28)
52. Are there special staff programs concerning the rehabilitation of the handicapped? 1____Yes 2____No (29)
53. Are there special stipends for staff to obtain an undergraduate degree?
1____Yes 2____No (30)
- A graduate degree pertaining to your work? 1____Yes 2____No (31)
54. Is there released time for staff to obtain an undergraduate degree?
1____Yes 2____No (32)
- A graduate degree pertaining to your work? 1____Yes 2____No (33)
55. What other efforts are made in in-service training? (Check all that apply)
- 1____Motion Pictures (34)
- 2____Special Speakers
- 3____Special Case Conferences
- 4____Conferences, Local (35)
- 5____Conferences, Out of State
- 6____Research Projects
- 7____Memberships in Professional Organizations (36)
- 8____Other_____ (37)
- (Specify)
56. What incentives are available in your agency that are conducive to furthering your education? (Check all that are applicable) (38)
- 1____Agency will pay for tuition only.
- 2____Agency will pay for books only.
- 3____Raises in salary with academic growth.
- 4____Promotions are based in part upon academic growth.
- 5____Memberships in professional organizations are paid.
- 6____Agency will pay for special course work and training.
57. Time spent in research activities is:
- 1____Required
- 2____Encouraged
- 3____Not encouraged
- 4____Not required

How much time do you feel should be spent in research activities? (40)

- 1 _____ None
- 2 _____ 10%
- 3 _____ 20%
- 4 _____ 30%
- 5 _____ 40%
- 6 _____ 50%

How often do you consult with your Vocational Rehabilitation representative about your client? (41)

- 1 _____ Never
- 2 _____ Seldom
- 3 _____ Occasionally
- 4 _____ Frequently

Do you know your Vocational Rehabilitation representative? 1 _____ Yes 2 _____ No (42)

Does your local Rehabilitation representative make regular calls on your office? 1 _____ Yes 2 _____ No (43)

Has your local State Vocational Rehabilitation representative ever talked to you about the requirements for eligibility for services? 1 _____ Yes 2 _____ No (44)

How much communication do you have with your local Vocational Rehabilitation representative? (45)

- 1 _____ None
- 2 _____ Infrequently
- 3 _____ Fairly often
- 4 _____ Frequently

How much communication do you have with the Services for the Visually Impaired? (46)

- 1 _____ None
- 2 _____ Infrequently
- 3 _____ Fairly often
- 4 _____ Frequently

What percentage of your clients are eligible for Rehabilitation services? (47)

- 1 _____ None
- 2 _____ Less than 10%
- 3 _____ 10 to 20%
- 4 _____ 20 to 30%
- 5 _____ 40 to 50%
- 6 _____ 50 to 75%
- 7 _____ 75 to 100%
- 8 _____ Don't know

*65. In your dealings with the Division of Rehabilitation Services, what delays or prevents services for your client? (Check to left of statements below, all statements that are applicable.)

- | | | |
|---|--|---|
| 1 | Lack of knowledge of the program | 1 |
| 2 | Lack of Rehabilitation Counseling Personnel | 2 |
| 3 | Eligibility requirements of Vocational Rehabilitation Service | 3 |
| 4 | No Vocational Rehabilitation Services office convenient to this area | 4 |
| 5 | Lack of local Rehabilitation facilities | 5 |
| 6 | Funding limitation of Rehabilitation Agency | 6 |
| 7 | Have no dealings with Rehabilitation Services | 7 |

*66. In your dealings with the Services for the Visually Impaired, what delays or prevents services for your client? (Check to the right of the statements above, all statements that are applicable.)

